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ABSTRACT

This document presents testimony and prepared statements from the Congressional hearings on teen parents and their children. The opening statement is presented, giving an overview of the problem of teenage pregnancy and parenthood and the negative short- and long-term consequences for the teens, their babies, their families, and society at large. Statements from witnesses are given including those of Dr. Wendy Baldwin, Center for Population Research; Dr. Effie Ellis, a health consultant; Judith E. Jones, Center for Population and Family Health, Columbia University; Elizabeth A. McGee, National Child Labor committee; Maurice Weir, Cities-in-Schools, Inc., Washington, D.C. and Edward A. Wynne, University of Illinois. Additional prepared statements, letters, and supplemental materials are included. Statistics on teenage sexuality and pregnancy, abortion, and contraception are highlighted. The effects of early parenthood on the education, health, and life satisfaction of the teenage mother and father are discussed, as well as the impact on their parents and society. The special risks of the children of teenage parents are described. The prevention of pregnancy and the responsibility of the family, school, church, government and society are emphasized. The need for sex education before the teenage years is noted, and the relationship of early sexuality to suicide, drug abuse, youth homicide and other problems is discussed. (JAC)

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ED245146

TEEN PARENTS AND THEIR CHILDREN: ISSUES AND PROGRAMS

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, D.C. ON JULY 20, 1983

Printed for the use of the
Select Committee on Children, Youth, and Families

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TEEN PARENTS AND THEIR CHILDREN: ISSUES AND PROGRAMS

WEDNESDAY, JULY 20, 1983

HOUSE OF REPRESENTATIVES,
TASK FORCE ON PREVENTION STRATEGIES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, D.C.

The task force met, pursuant to call, at 10:05 a.m, in room 2261, Rayburn House Office Building, Hon. William Lehman (chairman of the task force) presiding.

Present: Representatives Lehman, Schroeder, McHugh, Mikulski, Weiss, Leland, Miller, Bliley, Wolf, McKernan, and Marriott.

Staff present: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Karabelle Pizzigati, professional staff; Christine Elliott-Groves, minority staff director; Donald Kline, senior professional staff; Onalee McGraw, professional staff; and Joan Godley, committee clerk.

Mr. LEHMAN. Good morning. We will call the meeting to order of the Task Force on Prevention Strategies of the Select Committee on Children, Youth, and Families.

I will open it by reading my opening statement. By that time, Mr. Bliley will be here and have an opportunity to offer his opening statement.

In the first meeting of the task force, we learned about many issues and strategies that relate to the development of healthy babies and children and that contribute to healthy family functioning. Today we are continuing that examination by opening the committee's discussion of one of our most serious concerns, teenage pregnancy and parenthood.

We are all becoming increasingly aware of the scope, complexity, and gravity of this issue. More than 1 million teenage women reported pregnancies in 1980, and most of these were unintended, and probably unattended.

The patterns of the problems are changing and are complicated, but one thing is clear: These early pregnancies have considerable negative short- and long-term consequences for the pregnant and parenting teens themselves, their babies, their families, and society at large.

The problems have not gone away, but the enormity of the human and actual costs are just now being realized. For example, very young parents and their babies face substantially greater health risks than the general population. They also experience more serious social and economic difficulties since they often lack

adequate basic education and job skills. This makes it even more complicated.

My experience is that the problems of teen pregnancy and parenthood are particularly acute for young mothers, especially poor young mothers, who carry, bear, and have to assume the responsibility for the care of a child while they themselves are still children. I visited a crisis center in Miami and I met 28-year-old grandmothers.

We all know this is not a problem only for teenage mothers. This hearing initiates a careful inquiry into all the dimensions of the problem. With regard to today's hearing and future hearings, our attention will be focused on primary prevention and the delivery of services designed to reach at-risk teenagers more effectively and comprehensively; and not just teenagers, because I think sometimes you have to teach young women before they become teenagers. Let me say that even kindergarten is too late to start teaching very young. I think by the time they reach the teens, it is too late to start teaching them the facts of life about becoming pregnant. I think you have to start teaching them at 10 and 11 years old.

This is a problem we have got to face honestly. In my view, it all too graphically demonstrates the extent to which some traditional institutions are being outstripped by change.

Thank you for joining us and contributing to our discussion of this important issue.

Now, if Mr. Bliley is—there is Mr. Bliley. You could not enter at a better time. I have just given my opening statement and I will now yield to you for your opening statement.

Mr. BLILEY. Thank you, Mr. Chairman. I am sorry I am late. When I got to the front door, they had it barricaded.

Mr. LEHMAN. At your house?

Mr. BLILEY. No. [Laughter.]

Thank you, Mr. Chairman. I am very pleased at the opportunity we have today. The problems surrounding the issues of teen pregnancy and teen parenthood have surfaced again and again in our previous hearings. We have heard repeatedly of the way in which early sexual activity and resulting pregnancies of young and very young girls are major contributing factors to so many of the problems which we address in this task force.

Young, unmarried teens, by the very fact of their youth, by the fact of their physical, emotional, and intellectual immaturity, are ill-equipped to be parents. By entering into sexual activity in their early teens, they put themselves at risk to be uneducated, poor, and jobless for a major portion of their lives.

They put their children at even greater risk, starting with their increased likelihood to be born premature and underdeveloped; to be abused during their early years; to grow up without the benefit of a father's support and guidance; to enter into delinquent and criminal activity; and finally, to become parents themselves when they are still only children.

As a task force created to examine strategies of prevention, we are compelled by what we have learned thus far to make adolescent pregnancy, and thus adolescent sexual activity, two of our top

priorities. It cannot be argued that the Federal Government has ignored these problems in the past.

Since the creation of the Office of Family Planning in 1971, the consistent use of contraceptives by sexually active teenagers has doubled. Moreover, during that time, there has been a major shift among teens from the use of the less effective, nonmedical methods of contraception toward the use of the more effective medical means, such as the pill and the IUD.

It comes as a surprise, then, to find that the number of out-of-wedlock births among teens has not decreased during this period; in fact, it has increased, as has the number of abortions to unmarried girls.

Out-of-wedlock births have risen from 190,000 in 1971 to 262,000 in 1979. Abortions to unmarried teens have more than tripled from 124,000 in 1971 to 444,000 in 1979. The number of abortions remains nearly double the number of live births for this group.

Taking all these statistics together, it is shocking to note that the number of out-of-wedlock teen pregnancies more than doubled between 1971 and 1979 during the same time that the rate of contraceptive usage doubled, largely with the support of the Federal Government.

This rise in adolescent pregnancy, in fact, seems simply to mirror a similar rise in adolescent sexual activity.

These facts, as I say, come as a surprise to many of us, especially if we have been working under the assumption that increased use of medical methods of contraception must necessarily bring down the teen pregnancy rate.

Apparently, we were missing something. There are causes of high pregnancy rates which are not accounted for by our previous thinking. For this reason, it seems to be time to examine our assumptions, to examine the conventional mechanistic approach to pregnancy prevention, and to look a little deeper into the very complex, very human causes of adolescent behavior as it relates to sexual activity and pregnancies.

Fortunately for us, there are many individuals and organizations who have anticipated our questions. They have been working with young people for many years and are, as the saying goes, "way ahead of us." They have come up with the answers, and in many cases, have put those answers to work.

Some of them, such as Cities In Schools, a project represented here today by Mr. Maurice Weir, are already receiving support from the Federal Government under the newly created adolescent family life program of the Department of Health and Human Services.

All of them present us with ideas worthy of our attention. I welcome the testimony of our witnesses today and thank them for the experience and understanding they bring to this forum.

I would also like to add that we are presently awaiting the written statements of two other very valuable witnesses who could not be with us today. They are Dr. Edward Brandt, the Assistant Secretary for Health, and Mr. Gordon Jones, executive director of the United Families of America.

I request that the record be kept open, Mr. Chairman, for the receipt of their testimony.

Mr. LEHMAN. Without objection.

[Prepared statement of Edward N. Brandt, Jr., follows:]

PREPARED STATEMENT OF EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Prevention Strategies Task Force of the Select Committee on Children, Youth, and Families:

I appreciate the opportunity to discuss the role of the Department of Health and Human Services (HHS) in addressing the issues of pregnancy among the adolescent population in this country, and the special needs of pregnant and parenting teens and their children. In my remarks, I will first review the nature and extent of adolescent sexuality, pregnancy, and childbearing from the perspective of the young mother, the child, and our society. Then I will turn to an analysis of efforts to deal with these developments in HHS with particular emphasis on the activities of the recently enacted Adolescent Family Life Program.

Unintended early childbearing poses serious socio-economic and health problems for the young parents, and their child, and society as a whole. While considerable progress has been made at the Federal, State, and local levels in reducing adolescent fertility and in alleviating adverse consequences which might be associated with early parenthood, much remains to be done.

EXTENT OF THE PROBLEM

One of the major reasons for the continued problems is the dramatic increase in premarital sexual activity among American teenagers.

According to national surveys, the percentage of never-married sexually active females ages 15–19 living in metropolitan areas, rose from 28 to 46 percent between 1971 and 1979. Data on the percentage of sexually active male teenagers were not collected in earlier surveys; however, in 1979, 69 percent of never-married males, ages 17–21 in metropolitan areas, were reported to be sexually active.

While the percentage of sexually active teenagers using contraceptives increased during the same years, adolescent pregnancy has not decreased. Thus, the estimated pregnancy rate per 1,000 women for this age group rose from 94.8 in 1976 to 103.5 in 1980.

Although the rate of pregnancy has increased, there has been a reduction in the rate of childbearing—almost entirely the result of the increased use of abortions. Induced abortions among women ages 15–19 rose from 362,680 in 1976 (36.1 percent of all pregnancies) to 444,780 in 1980 (41.3 percent of all pregnancies). The abortion rate per 1,000 women age 15–19 was 34.3 in 1976 and 42.7 in 1980.

There are many negative aspects of early sexual behavior. According to the records of the Centers of Disease Control (CDC), the rates and numbers of gonorrhea cases reported by young women have risen dramatically during the 1970s from 57,458 total cases and a rate of 960.1 per 100,000 women aged 15 to 19 in 1970 to 147,245 cases and a rate of 1,414.5 in 1980. Similarly, although limited data exist on the incidence of genital herpes, CDC estimates that up to 20 million Americans of all ages may now be infected. Since adolescent premarital sexual activity has increased dramatically in the 1970s, it is entirely possible that genital herpes has reached alarming proportions among teenagers.

The adverse health effects of early childbearing to the mother have been well-documented. Although maternal mortality rates are declining, they continue to be higher for teen mothers (8.5 per 100,000 live births in 1978) than for those ages 20–24 (6.4 per 100,000 live births). There is increased risk for toxemia, anemia, prolonged labor, and premature labor. Teenagers are also at greater risk for miscarriages and still births.

Not only are young parents and their offspring likely to suffer from adolescent childbearing, but society is also often negatively affected, especially as a result of the increasing proportion of out-of-wedlock births among adolescents. In 1960, only 15 percent of all births to women 15–19 years old were born out-of-wedlock while by 1980 that proportion has risen to 48 percent. Almost all of these young mothers now keep their children rather than choosing adoption. Inasmuch as teenage childbearing significantly reduces the educational attainments and future employment prospects of the young mothers, it increases their likelihood of being on public assistance. A total of $8.55 billion went in 1975 to AFDC households in which the mother was a teenager at first childbirth. This sum provided AFDC payments, food stamps and Medicaid for both mothers and children.

While the short- or long-term consequences of early childbearing have been amply analyzed for the young mother, there is much less information on her child. Infants born to teenage mothers are more likely to die within the first year of life in large part due to the low birth weight of the child as the result of poor nutrition and inadequate pre-natal care. In 1980, 9.4 percent of babies born to mothers age 15–19 were of low birth weight compared to 6.9 percent of mothers age 20–24. Furthermore, while the percentage of low birth weight babies born to white teen mothers was 7.7, it was 13.5 percent for infants born to adolescents of all other races. Children of teenage parents are also less likely to be healthy at the end of the first year. The continuing socio-economic difficulties within these families also may contribute to the cognitive development problems of some of these children.

RESPONSES TO THE PROBLEM

This is a problem that can best be addressed by preventive measures either by (1) decreasing sexual activity or (2) improving contraceptive practices; or both. The Public Health Service is actively working in both areas.

The problems and suffering generated by the continued high rates of adolescent sexuality, pregnancy, and childbearing to a large extent can be eliminated or at least minimized by the concerted efforts of teenagers and their parents working together. The primary responsibility for dealing with these problems lies with the adolescent and the family. Concerned community organizations, trained professionals, and government agencies can and should help families and teenagers in coping with these difficulties, but they are not to be considered a substitute or alternative for the family. Furthermore, while the Federal government plays an important part, community and state agencies should be encouraged to take the lead in providing assistance.

The Federal government is assisting teenagers and their families through a variety of service programs. For example, the Public Health Service (PHS) is providing family planning services to sexually active adolescents as part of its overall goal of providing assistance to low-income women. In addition, PHS oversees the Maternal and Child Health Block Grant whose funds to States and Territories extend and improve services to reduce infant mortality and improve outcomes in adolescent pregnancies. The Department of Health and Human Services provides economic assistance to adolescent parents and their offspring through Aid to Families with Dependent Children (AFDC), Medicaid, and Social Security Supplements.

Similarly, the Office of Human Development Services (OHDS) administers the Social Services Block Grant, whose funds to States and Territories provide social services such as day care, child protection, foster care, and adoption counseling for the pregnant adolescent or young mother in need of these programs.

While there are a number of Federal agencies serving the needs of the entire childbearing population, few are specifically focused on the needs of the adolescent. The Office of Adolescent Pregnancy Programs (OAPP), was created both to address these problems directly and to co-ordinate other such activities within the Department of Health and Human Services.

The Adolescent Family Life Program, signed into law by President Reagan on August 13, 1981, funds Service Delivery projects to help pregnant teenagers, their children and families and sponsors prevention projects to reach teenagers before they become sexually active. By combining research with demonstration projects in prevention and care, OAPP takes a comprehensive and integrated approach to the problem of adolescent pregnancy.

Among the major features of this program:

Family involvement to help reduce teenage pregnancy and deal with the strains of adolescent parenting.

Comprehensive Care services for pregnant adolescents and adolescent parents which include adoption as a positive alternative for adolescents who do not choose to parent their child.

Prevention services provided within the context of the family, to reach adolescents before they become sexually active and maximize the guidance and support available to them from parents and other family members.

Research concerning the causes and consequences of adolescent premarital sexual relations, contraceptive use, pregnancy, and childrearing.

Evaluation of the relative effectiveness and efficiency of different means of service delivery.

Dissemination of results from programs and research projects relating to adolescent premarital sexual behavior, pregnancy, and parenthood.

Funds are allocated to eligible applicants proposing prevention and care programs which can serve as models for communities across the country as well as for research projects designed to provide needed information and analysis. In September 1982, the first AFL grants totalling $10 million were made to 50 demonstration programs located in 38 States, and to 12 research projects.

Although the initial findings are not yet available, there is every indication that they will play an important role in helping policy-makers at the Federal, State, and local levels in providing more efficient and effective ways of dealing with adolescent pregnancies. Fostering closer relationships at the local level with families of the adolescents will reduce the extent of premarital adolescent sexual activity and pregnancy, and providing assistance to young mothers and their children will help them become healthy and productive citizens of their communities.

The Select Committee on Children, Youth, and Families has an enormous and important mandate in the area of maternal and child health. I am sure your efforts today and in the future, will provide vital information regarding adolescent sexual activity and childbearing that will assist all of us. I am confident that through the Federal, State and local public and private partnership, we will make significant progress in reducing the problems and consequences in this area of great concern to all of us.

Thank you for the opportunity to address you on these important issues facing us today.

[Prepared statement of Gordon S. Jones follows:]

PREPARED STATEMENT OF GORDON S. JONES, EXECUTIVE DIRECTOR OF THE UNITED FAMILIES OF AMERICA

Mr. Chairman and members of the task force and committee: Thank you very much for this opportunity to present written testimony on the very important subject of teenage pregnancy and federal family planning programs. We are a grassroots organization of about 50,000 members interested in the formation of public policy and its impact on the family. We have for some time been interested in the approach commonly taken to teenage family planning by health professionals and government agencies. And we have for some time been convinced that these programs are not only ineffective but counterproductive.

The family planning programs supported by Federal tax dollars, with few exceptions, begin with the assumption that teenagers are sexually active, and that they are going to continue to be sexually active. That being the case, the best thing the government can do to reduce the rates of "problem pregnancies," which United Families of America defines as those ending in abortion, those occurring to girls under 15, and those occurring to unmarried minors, is to provide contraceptive information and contraceptives as widely as possible. The secondary assumption is that this technological approach will prevent teenage pregnancy.

We believe that the basic assumptions underlying these programs are wrong.

To begin with, the term "sexually active" is misleadingly imprecise. There is considerable evidence that many teenagers report themselves as "sexually active" on the basis of one sexual episode some time in the past. The phenomenon of "second virginity" described by Constance Lindermann in "Birth Control and Unmarried Young Women" is ignored. Lindermann's findings suggest that the actual rate of sexual activity may be lower than reported because of a failure to distinguish between those who are "currently sexually active" and those who have been sexually active in the past.

Thus when surveys show that "the average clinic user has been sexually active for 9 months to 1 year before coming to the clinic" they may be seriously overstating the case, and the need for their own services.

There is evidence, however, to show that once young women do attend family planning clinics, their rate of sexual activity increases. At least two Planned Parenthood surveys (Zelnick and Kantner, "Number of Sex Partners Not Increased by Giving Contraception to Teens," in Family Planning Perspectives, Vol. 10, No. 6 and Zabin and Clark, "Why They Delay: A Study of Teenage Family Planning Clinic Patients," in Family Planning Perspectives, Vol. 13, No. 5) clearly show that teenage rates of sexual activity increase after clinic attendance.

That is not really surprising. One of the goals of clinic counselors is to relieve guilt feelings, to help teenagers "come to terms with their own sexuality," and to provide contraceptives to reduce one of the main deterrents to sexual activity for teens: fear of pregnancy.

The most serious shortcoming of teenage family planning programs is its reliance on technology, and its failure to provide teenagers with guidance on sensitive moral

matters. United Families believes that this failure is the direct cause of the failure of federally-funded family planning programs.

And we do claim that these programs have failed.

In 1977, the ubiquitous Kantner and Zelnik (Family Planning Perspectives, Vol. 9, No. 2) noted that more and more teenagers were having sex more and more often. "[H]owever,' they thought, "these same young women reported a dramatic increase in overall contraceptive use, in use of the most effective methods, and in more regular use of all methods—changes which should have led to a decrease in premarital pregnancy." They didn't. "The lack of decline is somewhat surprising. . . ."

Rather than decline, premarital pregnancy increased dramatically, and if that is surprising to family planning experts, it is not surprising to the average person. It may be that the individual teenager is less likely to get pregnant if she is using contraception, but the attitude towards sexual activity in general which is communicated by "value-free" sex education and "non-judgmental" counseling is that such activity is expected, tolerated, all right.

Under the circumstances, it is not surprising that the average teenager is more likely to be having sex these days, or that teenagers of both sexes are having sex more often. To quote Columbia Teachers' College professor Diane Ravitch, "Frankly, it would be difficult to see how teenagers could spend a semester reading how to do it right, how good it feels when you do it, and how meaningful the experience is, without wanting to try it as soon as possible."

The kind of figures presented to your Task Force at the hearing 19 July indicate that they do try it, more and more often.

This quotation from Professor Ravitch is taken from an article from the New Leader, and while it deals with sex education, her comments also apply to the kind of "sexuality counseling" dispensed at most title X clinics. I attach the article for inclusion in the record.

Mr. LEHMAN. Thank you for your statement.

Mr. Leland.

Mr. LELAND. Thank you, Mr. Chairman.

I would like to take this opportunity to applaud your leadership, Mr. Chairman, and the staff's leadership for addressing yet another most important subject, teenage pregnancy. Too often this subject matter is used as a political springboard by opportunists who espouse alarming statistics and draw debatable conclusions.

I agree that it is alarming that there are over 1 million teenage pregnancies per year. Looking beyond simplistic statements about our moral decline, I am alarmed about those individuals who are involved in these pregnancies, both the parents and the children themselves.

First, the teen parents. Teen mothers have several medical problems, toxemia, anemia during pregnancy, prolonged labor, are less likely to get prenatal care and are most likely to have poor nutritional habits.

Further, teen parents are often associated with incomplete education, thus low-paying jobs and finally poverty-level existence. A study of 5,000 women at age 27 found that they earned almost $200 more per year for each year that they postponed the birth of their first child.

Teenage mothers have a much higher likelihood of being on welfare for longer periods of time than those who delay the childbearing. The probability that a mother would be on welfare at age 27 was reduced 2.2 percentage points for each year the birth of her first child was delayed.

Teen mothers also have more children, have their children born closer together, bear more unwanted children, and have more so-called illegitimate children than women who delay childbearing until their 20's.

Second, the babies of these pregnancies are more likely to be low weight and have a higher risk of complications and have somewhat slightly lower IQ's. These ill effects of teenage pregnancy and others should make this one of our Nation's highest priorities, Mr. Chairman.

I commend our panelists for sharing their knowledge with this committee and I look forward to a lively dialog on this most critical problem.

I thank the Chair.

Mr. LEHMAN. I thank you.

At this time, we will have our first witness, Dr. Wendy Baldwin. If you summarize any of your statements, of course, without objection, we will put the whole statement in the record.

You are on deck.

STATEMENT OF DR. WENDY BALDWIN, CHIEF, DEMOGRAPHIC AND BEHAVIORAL SCIENCES, CENTER FOR POPULATION RESEARCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

Dr. BALDWIN. Thank you, Mr. Chairman. I would like to summarize some of my statement and, of course, answer any questions that you might have.

I am pleased to be able to address this task force of the committee regarding the trends in adolescent pregnancy and childbearing and the consequences of early teen childbearing.

As I talk about the trends, I really have one main message that I want to get across, and that is that there is no one statistic that enables us to understand what has happened in early childbearing in the past decade. This is a situation where you must take several pieces of information and put them together and see what the whole picture has been.

For example, during the 1970's, the birth rates to teenagers were falling quite substantially. The numbers of births were falling a little bit. That is, of course, a result of the post-World War II baby boom; in the 1970's, we were flooded with teenagers.

But if the birth rates were declining and the number of births were moving down a little, one might find it difficult to see what the problem was. Well, I would suggest that one needs to look more closely at the statistics on the trends to see what exactly is changing. The first aspect that I call to your attention is the age of the mother.

During the 1970's, teenage childbearing became increasingly concentrated among young teenage women. We talk about teenage childbearing, but we are talking about women 15 to 19, generally, or under 20. This includes women who have the likelihood of a very poor pregnancy outcome and who are at risk of many, many social problems as a result of that birth. It also includes married 18- and 19-year-olds, whose problems certainly are quite different.

Over this period, the birth rates actually went up for some of the youngest teens so that in 1960, there were 7,500 births to women under the age of 15; by the early 1970's, that had risen to 13,000. There are now about 11,000 births to young teens each year. The

birth rates fell fastest for the older teens and they are the ones who probably face the fewest problems.

The second aspect of early childbearing during the 1970's that is important to consider is the marital status of the mother. Her marital status is important because we know that the unmarried mother is more likely to delay getting prenatal care; she is more likely to have fewer economic resources; and her child is more likely to have problems, either problems of complications of labor or social and development problems afterward.

As has already been pointed out, the number of out-of-wedlock births to teens has risen dramatically, from under 100,000 in 1960 to over 270,000 in 1980. Another way to look at these statistics is to look at the increased concentration of teen childbearing among the young and among the unmarried. Let us assume that births to 18- and 19-year-olds who are married are less problematic. In 1960, they had 62 percent of all the teen births; in 1980, they had only 38 percent of all of the teen births—thus by 1980, there was a total reversal with births to young teens accounting for a majority of all births.

A third aspect of the trends in the past decade that I want to review with you is trends in sexual activity. We have seen from survey data that in the 1970's, the proportion of unmarried teenage girls who were sexually active rose quite substantially. In the beginning of the decade, it was about a quarter, 26 percent. By 1976, it risen to 36 percent; by 1979, it had risen to 42 percent. So we have seen not only a surge in the number of teenagers, but a real increase in the number of teenage girls who are sexually active, and who are at risk of a pregnancy. These are the girls we have to be particularly concerned about.

So far I have talked about trends in birth, but of course we are also interested in what the trends in pregnancies have been as well. One can take the live births and induced abortions and generate some measure of conceptions. This eliminates miscarriages and late fetal losses, but they are both very hard to estimate and unlikely to change over a short period of time.

But we can make an estimate of the number of conceptions and this does show an increase. I have calculated figures from 1974 to 1979 and you see a 14-percent increase in the number of conceptions.

We have just seen that the number of teens who are sexually active has been rising quite substantially. I think we ought to go back and look again at those statistics and say, if a girl is sexually active, what is her chance of becoming pregnant? Has that changed over time?

When you make that adjustment, you see that the likelihood of a teen girl who is sexually active becoming pregnant has fallen 1.2 percent over this period of 1974 to 1979. Again, I would caution you that you need to take a number of different slices of this problem to get a comprehensive picture of what the trends have been.

I have also been asked to address the committee in terms of the consequences of adolescent childbearing. First, I would like to talk about the consequences for the mother because they appear severe and we have considerable data that address them.

I do not mean to say that all teenage mothers will end up with their lives in total ruin; that they will be poor mothers; and that their children will all end up in homes for juvenile delinquents. That is certainly not the case. There are many teenagers who are competent parents and who, in fact, are able to manage their lives quite well.

Notwithstanding, we know clearly from research that having a birth as an adolescent is a condition that puts a number of hurdles in front of that girl, and we know that she will be still jumping over those hurdles years and years after that birth. Obviously there are teens who do quite well, but on the whole, when a teen is subjected, in effect, to an early birth, she has a number of difficulties to overcome.

The first relates to her future childbearing behavior. As has been pointed out, the girl who begins her childbearing as a teenager is likely to have more children during her life, more unwanted children, more children born out of wedlock, and have a faster pace of childbearing than a woman who delays her first birth until she is out of the teenage years.

This early and rapid entry into family formation is unfortunately not associated with marital stability or marital satisfaction. We know that the rates of marital disruption, separation and divorce are much higher the younger the teen is when she marries. Interestingly, enough, if you look even further into her life, she is at a greater risk of having a second marriage break up than a woman who did not begin childbearing as an adolescent.

We have looked at all of these effects, short-term, medium- and relatively long-term, and the problems stay. They are not transitory problems that in a year or two are over.

The second main area, and the one that you all have paid considerable attention to already, is the impact of early childbearing on education and occupation. Early childbearing is a risk condition for reduced educational attainment for young women. One study shows that young women who became mothers while teenagers did have somewhat lower aptitute, lower interest in school, and lower aspirations. So you might say, these girls were probably different before they had that baby. Notwithstanding, if you control, statistically, for their aptitude, for their aspirations, for their interest in school, the young woman who has a birth when she is a teenager is still at a loss in terms of education relative to the teen who does not have a birth. Her educational attainment is still reduced. Preexisting differences do not fully explain the effect of an early birth on schooling.

Young mothers are also more likely to express regret over their educational careers. I keep coming back to that because I want to make sure that we realize that this is not only the researcher's perspective or my perspective. We have evidence from what the teenagers say about how childbearing has affected their lives.

The effect of adolescent childbearing on education is particularly important because education is a main pathway to economic attainment and success. The teen mother is faced with not only more mouths to feed because of higher fertility; but because of marital disruption, she is more likely not to have another wage earner in the home. She is likely to have fewer educational resources and

this all combines to generate a picture of economic distress later in life.

We have only a little research that addresses the effects on the father. One study found that the adolescent males who were involved in early childbearing looked better initially in terms of their employment and their earnings, but what it meant was that these men were not in school; they were out working earlier than they would have been otherwise. When you follow them a decade later, you find that they are not doing as well. In fact, they are doing worse than their peers who were not involved in early fatherhood.

Early childbearing probably has very little effect on the adolescent male who is involved in an early pregnancy but is not married to the mother, because we find very low patterns of involvement of the father of an out-of-wedlock birth with that child. This lack of involvement shows up both for the financial contribution and for what you could call the social contribution: Time spent with the child. These are not tradeoffs such that if a father cannot provide money, he provides time. They go together. And it is usually neither.

You have alluded to the concerns about the effect on the child. using "population-based" studies if you look at all the babies born and then you ask, of those babies born to teenage mothers, how do they look relative to those born to older mothers, they do not look as good in terms of birth weight, in terms of the prenatal care, in terms of infant mortality, or in terms of many indices we use to evaluate them.

When you take another population and ensure that everyone gets adequate prenatal care, you find a very different picture. You do not find the babies born to the adolescent mothers of this group showing decrements in their development or health at birth.

I think the conclusion from that is pretty straightforward: The effect of the age of the mother on the outcome of that pregnancy is virtually entirely mediated by the kind of prenatal care that she receives. I am using "prenatal care" in a very general sense; I cannot distinguish between vitamins and nutritional supplements and numbers of visits, but in general, it is the quality and the amount of the care that the young woman receives that accounts for the risks that those babies face.

Studies that examine the child's later development have shown that the mother's age at the child's birth, and social factors, are related to subsequent physical health and development. Interestingly enough, the category where the risk is the greatest is the one where the teenage mother is living alone. If the teenage mother has access to another older adult to help in the child rearing, she and the child do much better.

Other studies have looked at social, emotional, and cognitive development of these children later in life—as you have reported, we do see some studies showing lower IQ in the children born to teens. We know that teenage childbearing is associated with some of the social factors that are related to IQ, such as education, income, occupational status; these largely account for the effect of early childbearing on IQ.

One of the most difficult areas to research is the consequences of early childbearing for the adolescent's parents. Many of these par-

ents, usually the mother, are involved in child care and support after the young woman gives birth.

One study found approximately 70 percent of the teen mothers were living with one or both parents at the time of the birth. Five years later, a third of them were still living with those families, so we have been concerned about what is the effect on the family.

The families usually provide room, board, and child care. There does not seem to be an impact on that family's economic well-being, marital happiness, or stability. One study very interestingly showed that, at least initially, having the young woman and the baby back home provided almost a honeymoon period in the family. That did not last. Although the adolescent mothers and their families showed various styles of coping, the adolescent was more likely to see the mother as more controlling, more dissatisfied with her, and less affectionate than before the birth of the baby.

I think this is an interesting observation. There are some who feel that having a baby is a way of pulling away from the family, which it may be. But, in fact, studies of the adolescent who keeps the baby, that she is very dependent on the family, in fact, just the reverse of what she may have been expecting.

We have a little research that has addressed the consequences for society and I am going to reflect on only one. Since we have seen conditions where the mother has fewer economic resources and possibly more dependence, it is not surprising that she is at a greater risk of requiring welfare support at some time.

A 1975 study showed that 61 percent of women aged 14 to 30 living in AFDC households had their first child as adolescents. This accounts for an enormous amount of AFDC expenditures. It would be erroneous, of course, to assume that if we were to cure the problems of teenage childbearing that we would then have no AFDC costs because, of course, some of these women would probably require AFDC support at some time, regardless. But it is a significant component of the AFDC costs.

I would like to conclude with some thoughts about the size of this problem. In 1980, there were over 1 million pregnancies to women under the age of 20, and of course, the number of individuals affected is much greater. These young women have families, parents, brothers and sisters, husbands and boyfriends. Among girls who are now 14, it is estimated that 40 percent will experience a pregnancy before they get out of their teens and that 20 percent will give birth. Even more sobering than those numbers, I would warrant, is that the large majority of these pregnancies are unintended by the young women themselves. In addition to my testimony, I have attached several articles that provide the statistical data from which this was derived.

I have gone over the material rather quickly, so I would be happy to answer questions now and will stay for the rest of the hearing if there are further questions.

[Prepared statement of Dr. Wendy Baldwin follows:]

PREPARED STATEMENT OF DR. WENDY H. BALDWIN, PH.D., CHIEF, SOCIAL DEMOGRAPHER, DEMOGRAPHIC AND BEHAVIORAL SCIENCES BRANCH, CENTER FOR POPULATION RESEARCH, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

I have been asked to address this committee on the trends in adolescent pregnancies and births and to review the consequences of early childbearing. Adolescent fertility behavior has received so much attention in recent years, that most have already heard much about trends and may find it strange that there can be disagreement over just what the trends have been. To put early childbearing into perspective it is important to understand the post World War II baby boom. This was not a temporary phenomenon--an explosion that is quickly over--but rather a rise in the birth rate that lasted into the early 1960's. The aging of the baby boom babies meant that during the 1970's the number of teenagers was 43 percent higher than in the preceding decade. The baby boom was a dramatic demographic event which will continue to influence our society for many years to come.

Its implication for us is simple; it means that although the birth rates for most teens were declining in the 1970's, the number of births rose to 1970 and declined slowly thereafter. Since birth rates and numbers of births were falling faster for older women, the proportion of births to teens actually rose. If we looked no further we might conclude that adolescent childbearing was not a problem and that the appearance of a "problem" was an artifact of the structure of the population. However, more careful review of the components of the birth rate gives a different picture.

Age of Mother

When demographers talk about teenage childbearing, they generally refer to births to women under the age of 20. Indeed, statistics are made available for five year age groupings, and most teen births are to women 15-19. However, this groups together women who may have completed high school and who have

very good pregnancy outcomes with young women who may be in junior high school and who are high risk obstetrical patients. During the seventies the birth rates fell fastest for the oldest teens and actually rose for the very youngest, those under age 15. These constitute a very small percentage of all births (less than one-half of one percent), but youngsters under 15 are viewed as high risk from both a social and medical standpoint. While births to women under 15 were under 7500 in 1960 they rose to almost 13,000 in 1973 before declining to the present level of about 11,000.

Marital Status of the Mother

During the seventies the number of babies born to unmarried women rose significantly from under 100,000 in 1960 to almost 200,000 in 1970 to over 270,000 in 1980. In fact, in 1980 almost half (48 percent) of births to teens were out-of-wedlock as contrasted with 15 percent in 1960. Marriage rates fell sharply during the seventies for teenage women. The rate at which single teens bore children rose, but does not approach the rate for single women 20-24. Births to unmarried mothers are frequently associated with poorer prenatal care as well as with lower economic resources.

Trends in Sexual Activity

A significant change during the seventies was the increase in the likelihood that an unmarried adolescent girl would engage in sexual intercourse. In 1971 little more than a quarter (26.8 percent) of never-married women 15-19 reported that they had engaged in sex. By 1976 the proportions had risen to 36 percent, and using data from metropolitan areas, we can project that 42 percent of never married teens were sexually active in 1979. These data also show that in 1971 there was no age where half of the girls were sexually active and in 1979 it is only among the 18-19 year olds that half (or more) report having engaged in sex.

Trends in Pregnancies

Of course, not all pregnancies end in a live birth. 10 to 20 percent are lost through miscarriage, a small proportion are lost late in pregnancy or through stillbirth, and others result in an induced abortion. Data for abortions can be combined with data on live births to estimate rates of conception. These calculations show that between 1974 and 1979 there was a 14 percent increase in the number of conceptions. (I have not included miscarriages, stillbirths and late fetal losses in this estimate because of data problems and the assumption that patterns would not change much in such a short time period.) We have just seen, however, that most female teens are not sexually active and that the proportion who are has increased significantly during the past decade. Also, marriage rates have been falling for teenage women. If the birth and conception rates are adjusted to take into account the proportion of young women who are sexually active, we find that the birth rate for those "at risk" has fallen 20 percent from 1974 to 1979 and that the "pregnancy rate" has been nearly constant, showing a 1.2 percent decline.

Consequences of Adolescent Childbearing

Concern about early pregnancy and childbearing revolves around the effects on the young woman, her child, the father, and other family members involved, as well as society as a whole. I will discuss the effects on the young woman's marital and family experience, her education, occupational and economic future and her life satisfaction. There is a strong association between younger ages at first birth and higher proportions of unwanted and out-of-wedlock births, a faster pace of subsequent childbearing, and higher completed fertility.

This early involvement in family life is not, however, associated with marital stability or satisfaction. Many studies confirm higher rates of marital separation, divorce and remarriage for teenage parents. Marical dissolution rates are higher the younger the adolescent is at the time of marriage, and those who marry young are likely to express regrets later about the marriage. The risk of marital dissolution is carried on through later life, and shows up in increased risks of marital dissolution in second marriages. For the adolescent mother who is not married, studies show that she is very likely to marry soon after the birth, and that she, too, is at high risk of divorce.

Education and Occupation

Women who become mothers while adolescents exhibit reduced educational and occupational attainment, lower income, and increased welfare dependency relative to their peers. One study shows that those who became mothers while teenagers had lower academic aptitudes, grades and educational aspirations to begin with, but another study found a detrimental effect of early childbearing on education even when controls were introduced for family background and motivation. The negative effect of an early first birth on education holds even when background characteristics are controlled, and is felt by both males and females, but the effect on women is stronger and increases over time. Young mothers are more likely to express regret over their educational careers.

The effect of adolescent childbearing on education is especially important since it affects occupation and earnings. A decade after high school, women who became mothers early were more likely to be working than their classmates but in jobs of lower pay and prestige and with less job satisfaction. Several

studies have shown that the effect of an early age at first birth on occupational attainment is a function of reduced education and, to a lesser extent, of increased family size. The relationship between educational attainment and economic well-being is strong, and there is consequently a significant association between early motherhood and later economic distress. Women who begin childbearing as teenagers have increased welfare dependency, and half of the families - at the time of a 1975 study receiving AFDC were families begun when the mother was a teenager. The effect of early childbearing on economic attainment continues over the years as well. Few of these women "catch up" to those who delayed family building.

Life Satisfactions

As noted above, young mothers do not appear able to catch up to their peers in terms of education, occupation or earnings; other studies show that their reaction to the timing of their births does not improve over time either. A longitudinal study found that soon after the first birth almost half (48 percent) of the teenage mothers said they wished the child had been born later or not at all. Three years later 78 percent said that, looking back, they would choose to have their first birth later. Another longitudinal study found that early childbearers were more likely to have educational and marital-related regrets. A study which looked at the mothers's psychological well-being when her child was in the first grade found that young teenage mothers were more likely than older mothers to report feeling very bad at this time.

Effects on the Father

Adolescent men also feel effects of fathering a child since they may drop out of school to go to work. One study found that initially more adolescent fathers

were working than their classmates, at jobs of about equal prestige, and were making more money. By 11 years out of high school, however, their classmates' investment in education had begun to pay off in higher income and more prestigious jobs. The fathers of the babies of unmarried mothers may not be as affected since they appear to play a minimal role in childrearing. One study shows that less than one-fourth were in weekly contact with the child's mother several years after the birth, and frequency of contact declined over the early years of the child's life. Maintaining social contact seems to be linked with providing economic support, rather than being a substitute for it. Many of these men had limited economic means, and none of the unwed mothers in this study received economic support from the child's father for all three years surveyed.

Consequences for the Children

A number of studies have assessed the consequences of adolescent childbearing for the children involved. Several have examined the effects of maternal age on pregnancy complications and the resulting risk to the newborn. Their findings suggest that the negative effects of maternal age on pregnancy and neonatal health found in population-based studies were largely mediated by the quality of health care received by the mother and infant rather than being a function of the mother's biological age.

Studies examining the child's later development have shown that mother's age at child's birth and social factors are related to the child's subsequent physical health and cognitive and social development. One study using measurements taken at one year of age found that children of parents with low socioeconomic status and children of unmarried mothers who live alone with their children generally show poorer physical health. In addition, children of older mothers, 25 years and over, were healthier than children of younger

mothers, except in cases where teenage mothers rely upon older women (e.g., grandmothers) for child care.

The social, emotional, and intellectual development past infancy of the children of adolescents continues to be related to mother's age at birth. Two studies have found a consistent tendency for children of adolescents to have slightly lower I.Q. scores than children of older mothers when measured at several ages up to seven years, and some effects of maternal age on social and emotional development have also been found. An analysis of several large U.S. data sets has shown that young mothers are at a clear disadvantage in terms of those socioeconomic variables that relate to I.Q. (occupation, education and income) and that these factors are largely responsible for any effect of maternal age on the I.Q. of the child.

Consequences for the Adolescent's Parents

The influence of adolescent childbearing on the parental family has been one of the least examined areas although there is evidence that the adolescents' kin—especially their mothers—are often drawn into child care and support. A longitudinal study in an urban area has found that most of the adolescent mothers were highly dependent on the family, especially during the first several years after the birth. Approximately 70 percent were living with one or both parents at the time of the birth, and more than a third were still residing with the parents five years later. Parents most typically provide room, board, and child care. Women who resided with their families during the five years after the birth were more likely to have graduated from high school, be employed, and not be on welfare. Other analyses show that the families do not experience disadvantages in their own socioeconomic

and family careers as a result of the teenagers' births. In one study, the families of pregnant adolescents report a sense of renewed happiness and cohesion following the pregnancy. However, observation of their interactions show the family's perceived "honeymoon" in the period surrounding the birth is followed by disillusionment and distress. Although the adolescent mothers and their families show various styles of coping with early parenthood, generally the adolescent is more likely to see her mother as more controlling, dissatisfied with her, and less affectionate than she did before the birth of the child.

Consequences for Society

Early childbearing also has an impact on society, for when individuals cannot realize their full educational and occupational potential, society loses their economic contributions. In addition, if early childbearers utilize public services more than other women public expenditures on programs such as Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps increase. In fact, AFDC mothers are more likely to have been teen mothers than were American women in general. Estimates of the public sector costs related to early childbearing indicate that half of expenditures went to AFDC households in which the mother was a teenager at the time she bore her first child. This total does not necessarily represent the amount that could be saved if all these mothers had postponed their first birth, since some would have required public assistance regardless of their age at first birth.

Further analyses addressed the relative impact of reducing births as opposed to mediating the effects of an early birth. For example, we measured the effect on public sector costs of no women under age 18 giving birth or of all

young mothers completing high school. The results show savings for all approaches, but much greater savings when a birth is averted. As we all know, prevention is preferable to remedial care.

I would like to conclude with some thoughts about the size of this problem. In 1980 there were over one million pregnancies to women under the age of 20. The number of individuals affected is, of course, much larger since these young women have parents, siblings, husbands and boyfriends. Among girls now aged 14 it is estimated that forty percent will experience a pregnancy before age 20 and that one-fifth will bear a child. Even more sobering than the sheer numbers is the fact that the large majority of the pregnancies are unintended by the adolescent herself.

I would like to submit for the record several articles which provide much of the data on which my testitmony was based.

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Trends in Adolescent Contraception, Pregnancy, and Childbearing

Wendy Baldwin

Adolescent fertility commanded a great deal of attention during the 1970s from policymakers, researchers, physicians, educators, parents, and teenagers themselves. In this chapter current trends in behavior, effects on health, and long-term impact are placed in perspective by comparisons with women of other ages and with different time periods.

Discussions of adolescent pregnancy and childbearing that treat women 15–19 years of age as an undifferentiated group have been soundly criticized for combining women with excellent expected medical outcomes who have completed their education and are likely to be married with those with poor expected outcomes who are in junior high school and are unlikely to be married. This type of grouping is defensible only when data are not available for finer gradations of age. In this overview, data are presented by single year of age for women under age 20 wherever possible. Data are presented by racial subgroups as well since such subgroups show differences in trends and in some behavior related to early childbearing.

BIRTH RATES

Are there more teenage pregnancies now than in the past? Is the risk of becoming a teenage mother greater now than in earlier years? Is there really an epidemic of teenager fertility behavior? To answer any of these

seemingly straightforward questions requires an understanding of the basics of population statistics. In the period 1960–1970, the number of births to women 15–19 years of age rose from 601,679 to 644,708. The total number of births in the United States fell from 4.3 million to 3.7 million, and so the proportion of births to teenagers rose from 14.3 to 17.5 percent. However, the birth rate for women 15–19 (births per 1000 women 15–19) fell from 91.0 to 69.7 because there was an increase in the teenage population during this period. The United States has experienced a distinctive demographic process which bears directly on the phenomenon of adolescent childbearing—the post–World War II baby boom. The birth rate in the United States began climbing after World War II, peaked in the late 1950s, and declined thereafter. Consequently, in 1960, the women aged 15–19 (born during 1941–1945) numbered about 7 million, and in 1970 female teenagers (born during 1951–1955) numbered close to 10 million, a 35 percent larger cohort.[1,2] The United States has passed through the period of maximal impact of the adolescent-aged population and is now seeing the number of births to teenagers declining along with the rates. In 1979 there were 549,472 births to women 15–19, reflecting a birth rate of 53.4. The number of births overall has also declined, and the proportion of births to women under 20 fell to 16.0 percent in 1979 from a high of 19.3 percent in 1973.[3,4] Teenage childbearing became more visible after 1960—a time when the birth rate for adolescents was declining. The change in the proportion of

Table 1-1. Number of Births to Women under 20 Years of Age: 1960, 1970, and 1979

Item and Age	1960	1970	1979
Total births			
Under 15	7,462	11,752	10,699
15–17	177,904	223,590	200,137
18–19	423,775	421,118	349,335
Total	609,141	656,460	560,171
Out-of-wedlock births			
Under 15	4,600	9,500	9,500
15–17	43,700	96,100	120,100
18–19	43,400	94,300	133,100
Total	91,700	199,900	262,700
Illegitimate births per 1000 unmarried women 15–19	15.3	22.4	26.9

Data from the National Center for Health Statistics.[1,3,4]

births to teenagers was the result of continued high numbers of births to teens in the face of reductions in the fertility of older women. There are many good reasons, however, for the recent wave of attention to early childbearing.

Since 1960 the decline in the number of births to teenagers has been concentrated in the older ages, the number of out-of-wedlock births to teenagers has risen, and the illegitimacy rate (number of out-of-wedlock births per 1000 unmarried women) has risen for teenagers (Table 1-1). Births

Table 1-2. Births per 1000 Women 14–19 Years of Age: 1920–1979

Period	14	15	16	17	18	19
1920–1924	3.6	11.9	28.6	57.9	93.1	125.4
1925–1929	3.9	12.3	28.5	55.6	86.9	114.0
1930–1934	3.4	10.9	25.2	48.6	75.3	99.0
1935–1939	3.7	11.5	26.0	49.0	75.0	97.9
1940–1944	4.0	12.7	27.8	52.2	81.7	109.2
1945–1949	4.9	15.5	34.1	63.7	99.4	133.0
1950–1954	5.9	19.3	43.1	79.7	123.1	162.6
1955–1959	6.0	20.1	45.7*	85.8*	136.2*	184.0*
1960–1964	5.4	17.8	40.2	75.8	122.7	169.2
1965	5.2	16.5	36.0	66.4	105.4	142.4
1966	5.3	16.4	35.5	64.8	101.8	136.1
1967	5.3	16.5	35.3	63.2	97.5	129.5
1968	5.7	16.7	35.2	62.6	95.7	125.2
1969	6.0	17.4	35.8	63.1	95.7	124.5
1970	6.6	19.2	38.8	66.6	98.3	126.0
1971	6.7	19.2	38.3	64.2	92.4	116.1
1972	7.1	20.1	39.3	63.5	87.1	105.0
1973	7.4*	20.2*	38.8	61.5	83.1	98.5
1974	7.2	19.7	37.7	59.7	80.5	96.2
1975	7.1	19.4	36.4	57.3	77.5	92.7
1976	6.8	18.6	34.6	54.2	73.3	88.7
1977	6.7	18.2	34.5	54.2	73.8	89.5
1978	6.3	17.2	32.7	52.4	72.2	88.0
1979	6.4	17.2	32.8	52.5	73.5	90.4
Decline from highest rate (*) to 1979	14%	15%	28%	39%	46%	51%

Data from National Center for Health Statistics.[7-10]

to young teenagers and to unmarried women are generally viewed as the most problematic, that is, most likely to be unwanted and to require public support. The trend in birth rates by single year of age confirms that during the 1960s and early 1970s the rate rose for young adolescents (15–16) and declined for older teenagers. In the late 1970s the birth rate for even the youngest teens began to decline and that for older teenagers (18–19) dropped to the lowest ever observed for that age group (Table 1-2).

There are substantial differences in fertility and fertility-related behavior between blacks and whites; the younger the adolescents, the greater are the racial differences in behavior. White teenage birth rates are compared with nonwhite rates (92 percent of nonwhite births are to blacks) by single year of age in Table 1-3. The ratio of nonwhite to white rates is over 1 at all ages, but is highest at the youngest ages. Since black adolescents begin childbearing at younger ages than whites, it is not surprising that they experience more second and higher order births during the teenage years (Table 1-4).

The rise in illegitimacy has largely been a function of increases in rates for whites. While the rate is higher for blacks, there has been a definite downward trend during the 1970s. Whites have shown a steady rise in the rate of births to unmarried women aged 15–19[2,4,5] (Table 1-5). The growth of out-of-wedlock childbearing raises concern because the marital status of the mother often affects access to both economic and social support. The number of out-of-wedlock births to women under age 20 increased from under 100,000 in 1960 to over 250,000 in 1979. During this time, the illegitimacy rate rose from 15.3 to 26.9 for women 15–19, a 76 percent increase. The percentage of births out of wedlock rose for all ages under 20 (Table 1-6) and for blacks as well as whites (data not shown). The increase in out-of-wedlock childbearing has been occurring simultaneously with an apparent reduction in the number of babies placed for adoption. In a 1976 survey of unmarried women 15–19 who had borne a child, 93 percent

Table 1-3. Teenage Births per 1000 Women Age and Race: 1979

Age	White	Nonwhite	Ratio of Nonwhite to White
14	3.9	18.8	4.8:1
15	11.7	44.6	3.8:1
16	25.0	73.0	2.9:1
17	42.8	103.3	2.4:1
18	62.9	129.5	2.1:1
19	80.0	144.9	1.8:1

Data from National Center for Health Statistics.[3]

Table 1-4. Teenage Births by Age, Race, and Birth Order: 1979

Age	White			Black			All Others		
	First Birth	Second and Higher*	Percentage First Births	First Birth	Second and Higher*	Percentage First Births	First Birth	Second and Higher*	Percentage First Births
Under 15	4,271	131	97	5,813	326	91	152	6	96
15	14,406	751	95	11,498	1,162	91	531	29	95
16	36,467	3,050	92	19,680	3,387	85	1,228	134	90
17	63,657	9,639	87	24,416	7,585	76	2,070	447	82
18	87,315	22,429	80	26,665	13,166	67	2,821	893	76
19	105,230	40,863	72	26,138	19,108	58	3,160	1,547	67

Data from National Center for Health Statistics.[3]
*Includes births for which order was not stated.

Table 1-5. Births per 1000 Unmarried Women 15–19 Years of Age, by Race: 1970–1979

Year	Black	White
1970	96.9	10.9
1971	99.1	10.3
1972	98.8	10.5
1973	96.0	10.7
1974	95.1	11.1
1975	95.1	12.1
1976	91.6	12.4
1977	93.2	13.6
1978	90.3	13.8
1979	93.7	14.9

Data from National Center for Health Statistics.[2,4,5]

reported that the child resided with them. This is an increase from 86 percent in 1971, a change which reflects the growing trend for white adolescents to keep their babies.[11] There may be increased social acceptance of a young single mother raising her baby; placing a child for adoption may be regarded as a solution of last resort that is not widely used when abortion or unmarried motherhood are seen as viable options.

ABORTION RATES

No overview of adolescent childbearing would be complete without a discussion of abortion. Adolescents account for one-third of the legal abortions performed each year in the United States. In 1979 there were over 400,000 abortions to teenagers; since there were fewer than 600,000 births to adolescents in 1979, abortion is clearly a significant aspect of teenage fertility behavior.

Table 1-6. Out-of-Wedlock Births among Adolescents: 1960, 1970, and 1979

Age	1960	1970	1979
Under 15	4,600 (68)*	9,500 (81)	9,500 (89)
15	8,700 (44)	19,300 (65)	21,800 (77)
16	15,100 (28)	34,000 (48)	41,300 (65)
17	19,900 (18)	42,800 (35)	56,900 (53)
18	21,800 (13)	47,500 (26)	66,400 (43)
19	21,600 (9)	46,800 (20)	66,600 (34)

Data from National Center for Health Statistics.[2,3,6]

*Percentage of births out of wedlock is shown in parentheses.

Table 1-7. Teenage Abortions: 1973–1978

Age	1973	1974	1975	1976	1977	1978
Under 15	11,630 (1.6)*	13,420 (1.5)	15,260 (1.5)	15,820 (1.3)	15,690 (1.2)	15,110 (1.1)
15–19	232,440 (31.2)	278,280 (31.0)	324,930 (31.4)	362,689 (30.8)	397,720 (30.1)	418,790 (29.7)
20–24	240,610 (32.3)	286,600 (31.9)	331,640 (32.1)	392,280 (33.3)	450,900 (34.2)	489,410 (34.7)
25+	259,930 (34.9)	320,270 (35.6)	362,340 (35.0)	408,511 (35.4)	456,010 (34.5)	486,290 (34.5)
Total	744,610	898,570	1,034,170	1,179,300	1,320,320	1,409,600

Adapted from Forrest JD, Sullivan E, Tietze C: Abortion in the United States, 1977–1978. Fam Plann Perspect 11:329–341, 1979. Henshaw S, Forrest JD, Sullivan E, et al: Abortion in the United States, 1978–1979. Fam Plann Perspect 13:6–18, 1981.

*Percentage of abortions by age is shown in parentheses.

Data on abortion come from two major sources. The Centers for Disease Control reports abortion surveillance data compiled from central state agencies and from hospitals or facilities in which abortions are performed. The Alan Guttmacher Institute reports the number of abortions based on a survey of health institutions and private physicians providing abortion services. Because the latter figure includes abortions performed in physicians' offices, it is higher than the Centers for Disease Control figure. The distribution of abortions by characteristics of the women is available from the Centers for Disease Control, and the two data sources may be combined to give estimates of the total number of abortions performed on women with given characteristics, such as age or marital status.[12,13]

The data presented in Table 1-7 show the increase in the number of abortions performed on teenagers from 1973 to 1978. Since the likelihood of a spontaneous abortion or stillbirth is unlikely to change over such a short time period, the number of births and abortions can be used as an estimate of the number of conceptions. Analyses of trends in adolescent behavior can be misleading, however, if the extent of sexual activity is not taken into account. The data from two national surveys conducted in 1971 and 1976 (Table 1-8) and a third survey of women living in metropolitan areas conducted in 1979 (Table 1-9) show substantial increases in sexual activity. The size of the population at risk of conception should not include the number of women in an age group, but rather the number of sexually active women. With a few assumptions, one can compare the "risk of conception" for broad age groups over several years. In Table 1-10 various data for the years 1974 and 1979 are compared. The proportion of women who were sexually active was estimated by a simple interpolation and extrapolation of the 1971 and 1976 data and an adjustment of the 1976 figures as a function of the 1979 metropolitan area study. Because many technical issues cannot be dealt with accurately, these estimates should be used for heuristic purposes

Table 1-8. Percentage of Never Married Women 15–19 Years of Age Experiencing Sexual Intercourse: 1971 and 1976

Age	1971	1976	Percentage Increase
15	13.8	18.0	30.4
16	21.2	25.4	19.8
17	26.6	40.9	53.8
18	36.8	45.2	22.8
19	46.8	55.2	17.9
Total	26.8	36.1	30.2

Adapted from Zelnik M, Kantner JF: Sexual and contraceptive experience of young unmarried women. Fam Plann Perspect 9:55–71, 1977.

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Table 1-9. Percentage of Never Married Women 15–19 Years of Age Experiencing Sexual Intercourse, Metropolitan Only: 1971, 1976, and 1979

Age	1971	1976	1979	Percentage Increase 1971–1979
15	14.4	18.6	22.5	56.2
16	20.9	28.9	37.8	80.9
17	26.1	42.9	48.5	85.8
18	39.7	51.4	56.9	43.3
19	46.4	59.5	69.0	48.7
Total	27.6	39.2	46.0	66.7

Adapted from Zelnik M, Kantner JF: Sexual Activity, Contraceptive use and pregnancy among metropolitan-area teenagers: 1971–1979. Fam Plann Perspec 12:230–237, 1980.

Table 1-10. Trends in Conception among Women 15–19 Years of Age: 1974 and 1979

Item	1974	1979	Percentage Change
1. Women 15–19	10,186,000	10,145,000	—
2. Birth rate (per 1000)	58.7	53.4	−9.0
3. Sexual activity			
Ever married	1,272,000	894,000	−29.7
Never married women who are sexually active	2,888,000	3,922,000	+35.8
Percentage never married who are sexually active	32.4	42.4	+30.9
4. Women at risk of pregnancy (ever married and sexually active never married)	4,160,000	4,816,000	+15.8
5. Births	594,400	549,500	−7.7
6. Births per 1000 sexually active	143.1	114.1	−20.3
7. Induced abortions	278,300	449,500	+61.5
8. Estimated conceptions (births and induced abortions)	873,700	999,000	+14.3
9. Conceptions per 1000 women	85.8	98.5	+14.8
10. Conceptions per 1000 sexually active women	210.0	207.4	−1.2
11. Abortions per 1000 sexually active women	66.9	93.3	+39.5

Adapted from Baldwin W: Adolescent pregnancy and Childbearing—Growing concerns for Americans. Popul Bull 31:1–36, 1980 (updated reprint).

rather than as precise estimates of the risk of pregnancy. For sexually active women aged 15–19, the risk of bearing a child fell even in the short period under review (line 6). Failure to take into account the increased likelihood of sexual activity would lead to underestimates of the decline in rates of childbearing (lines 2 and 6) and overestimates of a rising risk of conception (lines 9 and 10).

Although there has been a substantial increase in the number of abortions, there has been a smaller increase in the number of abortions per 1000 sexually active women (lines 4 and 11). The risk of conception has fallen only slightly, while the risk of bearing a child has fallen considerably because of an increased tendency to abort unwanted pregnancies. The role of induced abortion in the control of adolescent fertility should not be underestimated.

CONTRACEPTION

Patterns of Contraception

This analysis cannot address the extent to which contraception is responsible for the prevention of unwanted pregnancies, only the change over time. Zelnik and Kantner estimated the likely impact of current patterns of adolescent contraceptive practices on the number of premarital pregnancies in 1976.[14] While there were over 1 million pregnancies that year to women 15–19 (78 percent of them premarital), there would have been an additonal 680,000 in the absence of the use of contraceptives. On the other hand, if all who did not intend to become pregnant had been consistent users of contraceptives, there would have been about 40 percent fewer unintended pregnancies. A life table analysis by Zabin illustrated the potential reduction in premarital pregnancies achieved by the use of medically prescribed contraceptives.[15] If a method were begun 1, 6, or 12 months after first intercourse, pregnancies would be reduced by 60, 30, or 20 percent, respectively.

Other analyses indicated that contraceptive practice improved between 1971 and 1976 but that the risk of pregnancy remained about the same. According to the data from the 1971 and 1976 national surveys, about 28 percent of teenagers who had sexual intercourse experienced a premarital pregnancy; that rate was much higher for blacks (40 percent) than for whites (25 percent)[16] Only 11 percent of the teenagers who always used contraceptives experienced a pregnancy (6 percent for those using medical methods), whereas 24 percent of those who were irregular users became pregnant. Although contraception clearly reduces the risk of pregnancy, only 27 percent of the teenagers were regular users and 42 percent were irregular users.

Given the differences in birth rates by race, it is not surprising to find higher rates of sexual activity reported by black adolescents (Table 1-11).

Table 1-11. Percentage of Unmarried Women 15–19 Years of Age Having Experienced Sexual Intercourse by Age and Race: 1976

Age	Black	White	Ratio of Black to White
15	38.4	13.8	2.8:1
16	52.6	22.6	2.3:1
17	68.4	36.1	1.9:1
18	74.1	43.6	1.7:1
19	83.6	48.7	1.7:1

Adapted from Zelnik M, Kantner JF: Sexual and contraceptive experience of young unmarried women in the United States, 1976 and 1971. Fam Plann Perspect 9:55–71, 1977.

One indicator of sexual activity is rarely enough to give an accurate view of subgroup differences. White adolescents were more likely to have many partners (six or more) and to report having had sex six or more times in the 4 weeks preceding the survey.[14] This pattern was also found in a study of family planning clinic patients.[17] Black adolescents were less likely to have ever used a contraceptive (57 percent of blacks versus 72 percent of whites) and less likely to have used a method at first intercourse (34 percent versus 40 percent). However, black and white adolescents were equally likely to be regular users if they began using a contraceptive method at first intercourse (72 percent versus 69 percent), and blacks were more likely to have used a medical method as their first method (47 percent versus 20 percent). Among teenagers who were regular users, there were small differences in the likelihood of pregnancy among blacks and whites (11.2 percent versus 9.6 percent). Among irregular users, blacks experienced a higher risk of pregnancy (30.0 percent versus 22.6 percent), and among nonusers their risk was much higher (71.2 percent versus 52.2 percent). Similar proportions of blacks (29.8 percent) and whites (28.3 percent) reported that premarital pregnancies were intended. Among those not intending a pregnancy, more blacks than whites were not using a contraceptive at the time they became pregnant (89.0 percent versus 74.5 percent).[14]

Are teenagers using abortion in place of contraception? While many teenagers who obtain abortions were not using a contraceptive at the time they became pregnant, the aborters are twice as likely to have used a contraceptive previously than are women with other pregnancy outcomes. Luker examined the risk-taking by women of all ages who engage in unprotected intercourse.[18] The woman's perception of her risk of becoming pregnant, the availability of contraceptives, the cost of contraceptive use both in monetary terms and in terms of the sexual relationship, and the dynamics of the sexual relationship appear to influence whether a woman, or more rightly a couple, takes a chance on unprotected intercourse.

Inaccurate information regarding fecundity, the sporadic nature of adolescent sexual relationships, and the newness of dealing with such relationships may make teenagers especially vulnerable to miscalculations of the risk. In addition, some adolescents may not be sufficiently motivated to avoid pregnancy even when they are aware of the risk of conception. Zelnik and Kantner found that almost one-half of the nonvirgin women they interviewed had not had sex in the 4 weeks preceding the interview—51 percent among the 15- to 17-year-olds and 44 percent among the 18- to 19-year-olds.[16] Only 41 percent knew the time during the menstrual cycle of greatest risk of pregnancy. The teenagers' leading reasons for nonuse of contraception were a belief that it was the time of month of low risk, their youth, infrequent sex, or general belief that they could not get pregnant. These reasons were followed by the difficulty of obtaining contraceptives.[19] Even among those who had been contracepting regularly when they had an unintended pregnancy, 41 percent thought there was a good chance they might become pregnant despite their attempts to prevent it. This proportion is not much lower than the 55 percent of noncontraceptors who also felt there was a good chance they would become pregnant.

Unintended pregnancies appear to be associated with interesting patterns of perception about risk and also with interesting consequences. Data for whites in 1976 show that, as one would expect, unintended pregnancies were much more likely to result in induced abortion than were intended pregnancies (52.7 percent versus 11.8 percent); however, they were also much more likely to be reported as ending in miscarriage (17.1 percent versus 5.9 percent). It is difficult to tell whether these were really induced abortions or the result of actions that might have raised the likelihood of miscarriage.[11]

The woman's age has a strong impact on contraceptive behavior and consequently on the risk of pregnancy. Less than one-quarter of the girls under age 15 used a contraceptive at first intercourse, as opposed to 41 percent of the 15- to 17-year-olds and 55 percent of the 18- to 19-year-olds. The younger teenagers were more likely to begin contracepting with a nonmedical method than were the older teenagers, a factor which also contributed to the young teenagers' risk of conception. Zabin et al. studied 18- to 19-year-old women and looked at their experience with pregnancy soon after first intercourse: "nearly one-fifth became pregnant within six months of beginning sexual intercourse." Of those who became pregnant, nearly half of the pregnancies occurred during the first 6 months of exposure and one-fifth during the first month.[20] The first months of sexual activity are most risky because contraceptive behavior is often not yet established, and this risk is greatest for the youngest women. If a girl is under 15 when she first engages in sexual intercourse, she is nearly twice as likely to become pregnant in the first 6 months of exposure than if she is over age 17. Almost

10 percent of sexually active girls under age 15 become pregnant in the first month of exposure. Although it may be generally true that the risk of pregnancy is less when one is very young, especially during the first year after menarche, even for the youngest sexually active girls menarche generally precedes intercourse by 2 or 3 years.

Clinic Attendance

Research reports of the time between the initiation of intercourse and first clinic attendance often show delays of 6 months to 1 year. It is appropriate to focus on the delay in coming to a clinic since it is through the medical care system that teenagers get access to the most reliable methods of fertility control. Detailed data about the use of private physicians is not available, but adolescents use clinics for family planning services much more than do older women. A study conducted in 1980 by Zabin and Clark in a variety of family planning clinics sheds some light on the patterns and reasons for teenagers' delay in coming to clinics for contraceptives.[17] Some teenagers came for services before they were sexually active; this group included twice as many blacks (19.6 percent of the teenagers who attended the clinics studied by Zabin and Clark) as whites (10.1 percent). However, since more whites came within 2 months of first intercourse (10.9 percent as opposed to 5.7 percent for blacks), there were not large racial differences in the proportion arriving early in their exposure to the risk of pregnancy. The suspicion of pregnancy was the reason given by 36 percent of the young women for their first clinic visit. Zabin and Clark noted that "the mean interval from first intercourse to the first contraceptive visit of all sexually active clinic patients is 16.6 months, even though these are the select group of sexually active young women who do make it to a clinic and who have not been pregnant during their prior interval of exposure.[17] Nearly three-quarters of these young women had prior experience with contraception, either folk methods or reliable nonprescription methods. The time prior to coming to the clinic may also have been a period of low exposure to the risk of pregnancy given the sporadic nature of adolescent sexual activity. In general, the young women who were contraceptors before coming to the clinic were the ones who came relatively early; those who were poorer contraceptors or came in response to a pregnancy scare had delayed the longest.

Fear of pregnancy is clearly a powerful motivator for clinic attendance—for one-quarter of the young women surveyed it was the most important reason. Another major reason was that the relationship with the partner was becoming closer, a finding echoed in other studies. Other important reasons were that they expected to begin having sex, had just begun to have sex, or were having sex more often. For 10 percent of the women, another person (partner, parents, or another) helped motivate them to come. The main

reason they had delayed coming so long was that they just "didn't get around to it;" this response, Zabin and Clark noted, may indicate simple procrastination or a more complex ambivalence toward seeking contraceptives. The second most prevalent reason for delay was fear that their families would find out if they came. Others waited for the relationship with the partner to develop, possibly to see if they would be in need of contraceptive protection, while others expressed fear of a pelvic exam or a belief that birth control was dangerous. Some gave reasons that reflected an apparent disbelief in the risk of pregnancy either because they felt they were too young or because the other method they were using was sufficient.[17]

In light of the current interest in parental notification or consent for family-planning services for minors, it is interesting to compare the proportion of adolescents who reported fear of parental discovery delaying their first visit (31 percent) with those who reported that a parent suggested the visit (7.3 percent). More whites reported fear of discovery (35.2 percent) than blacks (25.4 percent), and more blacks reported parental urging (11.5 percent) than whites (3.0 percent). Fear of discovery was a prominent reason among those who came only under suspicion of pregnancy (40.2 percent) but did not discriminate between those who delayed a short while and those who came promptly. Teenagers whose parents suggested the visit were more highly represented among those who came while still virgins (12.0 percent); over 17 percent of the black but less than 2 percent of the white virgins reported being referred by a parent.[17]

Despite widespread concern about parental involvement, few clinics require notification or consent and they may only require it when the patient is quite young. A 1980 study by Torres et al. revealed that only 10 percent of the clinics surveyed had such requirements (excluding those with a requirement for consent or notification for IUD insertions only) when the patient was aged 16 or 17.[21] Almost none required it for those 18 or older, and 20 percent required it for patients 15 or younger. In this study of clinic attendees, 54 percent of those under age 18 reported that their parents knew of their attendance: 30 percent reported they told their parents voluntarily and 21 percent reported that their parents suggested the visit. The proportion who told their parents voluntarily was unaffected by whether the clinic had a consent or notification requirement, but the proportion of parent-suggested visits was higher in clinics requiring notification or consent.

Of the 41 percent who reported they were sure their parents did not know, 18 percent said they would come to the clinic even if notification were required, and 23 percent said they would not come. Most of those who would stop coming (15 percent of the total) said they would resort to nonprescription methods, 4 percent would have unprotected sex, and 2 percent would cease sexual activity. The authors noted that by extrapolating the findings of this survey to all teenagers less than 18 served by clinics, it

could be estimated that requiring parental notification or consent would result in 100,000 patients telling their parents about their use of contraceptives, but it would also result in 125,000 patients ceasing to use effective methods of contraception while continuing to be at risk of pregnancy. The teenagers who would stop contracepting or switch to less reliable methods would be at increased risk of an unwanted pregnancy and, by extension, to abortion. This survey indicated that 55 percent of girls under 18 who obtain abortions do so with the knowledge of their parents.

CONCLUSIONS

The role of parents in regard to adolescent sexual, contraceptive, and abortion behavior is complex. It is axiomatic in the social sciences that the family is a vitally important vehicle for socialization, and research points to the role of parental factors in influencing adolescent behavior. This influence appears in the transmission of general values and norms regarding the timing of marriage and childbearing. Parental characteristics relate to adolescents' involvement in school and their educational and occupational aspirations, which research shows are associated with fertility-related behavior. However, the role of parents in influencing the specifics of fertility control and sexual behavior is less clear.

Perhaps the most important conclusion from this analysis is the need to reach adolescents early, preferably before they have begun sexual intercourse. If parents and providers wait for the adolescent to seek a service, the adolescent may already be pregnant. This is especially true for the youngest adolescents, who may be the most difficult to reach. The likelihood of sexual activity among unmarried adolescents is fairly high and increasing—although it is not until age 19 that half are sexually active. Adolescents give many indications of wanting to control their fertility but have considerable difficulty in doing so. The youngest adolescents are the least likely to control their fertility, and they are more likely to end a pregnancy with an induced abortion than with any other outcome.

Given that the risk of pregnancy is high in the first months of exposure to sexual intercourse, and that teenagers tend to delay coming for an initial clinic visit (partly the result of their misperception of the risk of pregnancy and their difficulties in dealing with contraception and the health care delivery system), the focus should be on ways to reach adolescents before they are sexually active. The difficulties of such a plan are not trivial. For such an outreach program to occur via parents they have to become more willing and able to discuss sex and contraception and acquire an improved sense of when their child is "old enough" to be a candidate for sexual intercourse. In order for schools or other institutions to undertake such a campaign

parents' support would be required. The programs would have to reach age groups in which only a small percentage of the pupils would be genuine candidates for information about pregnancy risk and contraception. Service systems and/or counseling programs would be necessary to back up information. One possible step might be to target contraception education efforts at males since the male partner is likely to be a little older than the female. There is another major obstacle to reaching adolescents before they are sexually active. Parents and providers may believe that sexual activity is wrong or at least inappropriate for young adolescents, and therefore be reluctant to offer counsel about how to manage such activity. It is possible, however, for them to point out that for a young adolescent sex may be risky from a physical or psychological perspective, but still urge responsible contraceptive behavior should the adolescent become sexually active.

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Adolescent Sexual and Reproductive Behavior

Wendy H. Baldwin, Ph.D.

INTRODUCTION

The estimated 1 million pregnancies a year to women under 20 are accounted for by the more than 4 million sexually active young women. A quick calculation leads one to suspect that teenagers are at high risk of becoming pregnant if they engage in sexual activity, and so they are. While few married adult women expose themselves to the risk of an unwanted pregnancy, contraceptive practice among adolescents is less regular and less efficacious. This is one reason that adolescent sexual behavior has been the subject of increased attention in the past decade. During this time, women under age 20 contributed about 600,000 births a year in the U.S., or 15-20 percent of all births. Increasingly, births to teens were out-of-wedlock, and the social, economic, personal, and societal impact of teenage births was widely felt, recorded, and analyzed. Adolescents have accounted for one-third of the legal abortions annually, a figure that has topped 400,000 in recent years (Table 1). How many teens are sexually active, and how and why do they contracept? Why is sexual activity so often followed by pregnancy? Before answering these questions, another question must be addressed: how do we know anything about teenage sexual behavior?

SOURCES AND QUALITY OF DATA

The number of births is obtained from State records of births, records which include the mother's age, and in some states, her marital status, along with other information. Abortion data come from reports of hospitals, clinics, and doctors performing abortions. Information about adolescents' sexual behavior generally comes from surveys, the most promfnent of them being the Johns Hopkins surveys, conducted in 1971, 1976, and 1979. They are all national samples, but in 1979, data are available only for metropolitan areas. Can one believe answers given to surverys about intimate behavior? Probably. Answers can be checked against vital records to see if implied rates are "believable" and the internal consistency of replies can be studied. There is such internal consistency that it is difficult to believe that wholesale fabrication of data is taking place. Large numbers of cases mean that if someone shades the truth from time to time, there is little ove.all effect. A more serious problem comes from those who

Table 1. Childbearing and abortion in the U.S. - 1970-1978

	1970	1971	1972	1973	1974	1975	1976	1977	1978
Total number of births	3,731,386	3,555,970	3,258,411	3,136,965	3,159,958	3,144,198	3,167,788	3,326,632	3,333,279
Number of births to women									
under 20	656,460	639,320	628,362	616,957	607,918	594,880	570,672	570,609	554,179
under 15	11,752	11,578	12,082	12,861	12,529	12,642	11,928	12,455	10,772
15-17	223,590	226,298	236,641	238,403	234,117	227,270	215,493	213,788	202,661
18-19	421,460	401,644	379,639	365,693	361,272	354,968	343,251	348,366	340,746
Percent of births to women under 20	17.5	18.0	19.3	19.7	19.2	18.9	18.0	17.2	16.6
Total number of out-of-wedlock births	398,700	401,400	403,200	407,300	418,100	447,900	468,100	515,700	543,900
Number of out-of-wedlock births to women under 20	199,900	203,600	212,200	215,800	221,400	233,500	235,300	249,800	249,100
Percent of out-of-wedlock births to women under 20	50.1	50.7	52.6	53.0	53.0	52.1	50.3	48.4	45.8
Percent of all births to women under 20 that were out-of-wedlock	31.5	31.8	33.8	35.0	36.4	39.3	41.2	43.8	44.9
Total number of abortions	n.a.*	n.a.	n.a.	744,610	898,570	1,034,170	1,179,300	1,320,320	1,409,600
Percent of abortions to women under 20	n.a.	n.a.	n.a.	32.8	32.5	32.9	32.1	31.3	30.0
Number of abortions to women under 20	n.a.	n.a.	n.a.	243,440	293,420	342,300	378,500	413,410	422,900

Sources: National Center for Health Statistics (1,2,3,4,5,6,7,8,9,10), and Forrest, Sullivan, and Tietze (11).

* n.a.: not available

do not participate in these surveys. Since they may include young women living "on the street" and likely to be more active sexually as well as those whose parents refuse their participation and are probably less active sexually, it is difficult to know the total effect on survey results with any certainty. But the figures given are from samples and are, therefore, estimates. Clinic data and other data from special sources complete the picture. Such data often may be richer in content but more limited in scope, numbers of cases, and representativeness. All types of data may be used to help describe and explain adolescent sexual behavior.

SEXUAL ACTIVITY

Let me return to the sexually active adolescent, and in keeping with the focus of the conference and the weight of the available data, we shall limit ourselves to adolescent females. National data from 1971 and 1976 showed an increasing proportion of young women engaging in sexual activity before marriage, and a declining age of first intercourse (Table 2).

Table 2. Percent of never married women in the U.S. experiencing sexual intercourse, 1971 and 1976, by age and race

WHITE

	1976	1971	Percent of Change
15-19	30.8	21.4	43.9
15	13.8	10.9	26.6
16	22.6	16.9	33.7
17	36.1	21.8	65.6
18	43.6	32.3	35.0
19	48.7	39.4	23.6

BLACK

	1976	1971	Percent of Change
15-19	62.7	51.2	22.5
15	38.4	30.5	25.9
16	52.6	46.2	13.9
17	68.4	58.8	16.3
18	74.1	62.7	18.2
19	83.6	76.2	9.7

Source: Zelnik (12).

By 1979, the proportion who were sexually active had continued to grow, although there appeared to be no change in age at first intercourse (Table 3).

Table 3. Percent of never married women in metropolitan U.S. experiencing sexual intercourse, 1971, 1976, 1979

	Percent of Change, 1971-1979	1979	1976	1971
15-19	+66.7	46.0	39.2	27.6
15	+56.2	22.5	18.6	14.4
16	+80.9	37.8	28.9	20.9
17	+85.8	48.5	42.9	26.1
18	+43.3	56.9	51.4	39.7
19	+48.7	69.0	59.5	46.4

Source: Zelnik and Kantner (13, Table 1).

It appears that just under half of women 15-19 engage in sexual activity before marriage. When a comparison is made between 1976 and 1979 (metropolitan areas only), it is clear that the increase in sexual activity is among never-married whites. The prevalence of premarital intercourse is clearly higher for blacks, but the behavior of whites is changing more (13). Differences in sexual activity between blacks and whites are greatest at the youngest ages, a fact mirrored in the differences in age-specific birth rates (Tables 4a and 4b*).

Table 4a. Birth rates for women less than 25 in the U.S., 1970-1978, by race

ALL WOMEN

	1970	1971	1972	1973	1974	1975	1976	1977	1978
20-24	163.1	149.1	128.8	119.4	117.7	113.6	110.9	114.0	111.4
15-19	69.7	66.1	63.0	60.4	58.7	56.7	53.8	54.0	52.5
18-19	112.2	104.3	96.1	90.8	88.4	85.1	81.0	81.7	80.1
19	126.0	116.1	105.0	98.5	96.2	92.7	88.7	89.5	88.0
18	98.3	92.4	87.1	83.1	80.5	77.5	73.3	73.8	72.2
15-17	41.5	40.6	41.0	40.2	39.0	37.7	35.8	35.6	34.1
17	66.6	64.2	63.5	61.5	59.7	57.3	54.2	54.2	52.4
16	38.8	38.3	39.3	38.8	37.7	36.4	34.6	34.5	32.7
15	19.2	19.2	20.1	20.2	19.7	19.4	18.6	18.2	17.2
14	6.6	6.7	7.1	7.4	7.2	7.1	6.8	6.7	6.3

* Single year of age data are unavailable for blacks. Table 4a presents data by single year of age of all women, whites, and all other. Table 4b presents grouped data for blacks.

WHITE

	1970	1971	1972	1973	1974	1975	1976	1977	1978
20-24	158.6	143.9	123.7	114.3	113.0	108.7	106.1	108.9	105.4
15-19	59.0	55.2	52.3	50.3	49.1	47.4	45.1	45.1	43.7
18-19	99.6	91.7	83.8	79.0	77.3	74.3	70.9	71.2	69.6
19	114.0	103.9	93.2	87.1	85.5	82.2	78.8	79.3	77.6
18	85.2	79.5	74.4	70.9	69.0	66.3	63.0	63.0	61.5
15-17	32.0	30.9	31.3	31.0	30.4	29.5	27.9	27.7	26.5
17	54.3	51.8	51.2	50.0	48.7	46.9	44.3	44.1	42.6
16	29.0	28.6	29.5	29.5	28.9	28.1	26.6	26.4	25.1
15	12.6	12.4	13.2	13.6	13.5	13.4	12.8	12.6	11.8
14	3.6	3.7	4.1	4.3	4.3	4.4	4.2	4.1	3.9

ALL OTHER

	1970	1971	1972	1973	1974	1975	1976	1977	1978
20-24	189.9	179.7	159.8	149.2	143.7	140.4	138.0	142.2	142.3
15-19	133.4	129.1	124.7	118.4	112.4	107.6	101.7	101.6	98.4
18-19	186.8	178.5	168.3	158.2	150.8	145.0	137.0	138.3	136.0
19	197.7	187.9	175.0	164.0	156.5	151.0	143.6	145.3	143.5
18	175.8	169.1	161.5	152.3	145.0	138.9	130.4	131.3	128.5
15-17	97.9	96.2	95.4	91.6	86.9	82.7	78.1	77.3	73.4
17	139.3	135.8	133.7	126.5	120.4	114.5	108.0	107.4	103.5
16	96.3	95.3	95.6	91.6	86.8	82.3	77.6	77.0	72.5
15	58.0	57.6	58.2	57.0	53.6	51.2	48.6	74.4	44.1
14	23.8	23.6	24.1	24.5	22.8	22.1	20.5	20.0	18.5

Sources: National Center for Health Statistics (14,15,16,17).

Table 4b. Birth rates for black women less than 25 in the U.S., 1970-1978

	1970	1971	1972	1973	1974	1975	1976	1977	1978
20-24	202.7	187.3	166.2	154.6	148.7	145.1	143.4	147.7	147.5
15-19	147.7	135.1	130.8	124.5	118.3	113.8	107.0	107.3	103.7
18-19	204.9	193.8	181.7	169.5	162.0	156.0	146.8	147.6	145.0
15-17	101.4	99.7	99.9	96.8	91.0	86.6	81.5	81.2	76.6

Source: National Center for Health Statistics (9).

But now that we have reviewed data on the overall numbers, the rates, the racial differences, and the trends, does this help us picture the sexually active teen? Perhaps the data on frequency and number of partners will help. Drs. Zelnik and Kantner (13) note that about 12 percent of the sexually active have had sexual intercourse only once. Among those in 1976 who were no longer virgins, almost half had not had intercourse in the 4 weeks preceding the survey, and an additional 25 percent had had intercourse only once or twice (Table 5).

Table 5. Sexually experienced never married women 15-19 by frequency of intercourse in 4-week period by race and age

NUMBER OF TIMES

	0	1-2	3-5	6 or more	Total
1976					
All	47.6	25.4	11.7	15.3	100.0
White	49.2	21.2	12.2	17.4	100.0
Black	49.3	29.2	14.1	7.4	100.0
1971					
All	39.6	30.2	17.4	12.8	100.0
White	38.3	30.1	17.6	14.0	100.0
Black	40.1	34.0	17.6	8.3	100.0

Source: Zelnik (12).

(For comparison, among white married women, only 5 percent had not had sexual intercourse and 6 percent had had intercourse only once or twice in a comparable period for 1975 (16). In regard to premarital sex, one-half of the teens had had only one partner (Table 6).

Table 6. Sexually experienced never married women 15-19 by race and number of partners ever

NUMBER OF PARTNERS

	1	2-3	4-5	6 or more	Total
1976					
All	50.1	31.4	8.7	9.8	100.0
White	52.9	28.0	7.8	11.3	100.0
Black	40.2	42.0	11.8	6.0	100.0
1971					
All	61.5	25.1	7.3	5.6	100.0
White	61.6	22.9	8.5	7.0	100.0
Black	61.4	28.9	6.9	2.8	100.0

Source: Zelnik (12).

Why is frequency of sexual activity and number of partners of concern? Both dimensions of sexual behavior help researchers interpret the risk of pregnancy by improving our understanding of the extent to which teens are exposed to the risk of pregnancy. Such data also reflect on the teen's contraceptive needs and the milieu in which contraceptives will be used. For example, one could argue that occasional sexual activity is less compatible with the regimen of oral contraceptive use than is regular sexual activity (17).

When these features of sexual activity are considered, the comparison of blacks and whites becomes even more interesting. The likelihood that a black adolescent women will be sexually active is clearly higher than it is for a white, and she is likely to begin sexual intercourse at an earlier age, but once initiated, her behavior looks in many ways more conservative. The black adolescent is less likely to have had many partners (6 or more). The average number of partners in 1976 was 2.8 for whites and 2.4 for blacks. As noted before, frequency of sexual intercourse (as measured in the 4 weeks preceding the survey) was low but notably higher for whites, 3.0 for whites compared with 1.7 for blacks in 1976 (18).

An intriguing problem of separating cause and effect in cross-sectional data appears in the analysis of sex, contraception, and marriage plans, and the case is most clearly observed for whites. Sexual activity is most frequent for those using a medical method and for those with marriage plans. Perhaps the security of a medical method reduces fear of pregnancy and increases sexual activity, but the concomitant relationship with marriage plans leads one to suspect that an anticipated wedding both reduces barriers to effective contraception and increases sexual activity as pressures to hide sex--or the perceived costs of a pregnancy--are reduced (13).

Data on frequency and partners paint a fairly conservative picture of teenage sex. Sex--as Drs. Zelnik and Kantner point out--is more extensive among blacks but more intensive among whites. But for both groups the risk of pregnancy is high. One-third of those who had intercourse before marriage became pregnant before marriage (13). One out of three is terrible odds, especially considering irregular and infrequent sexual activity!

PREGNANCY--THE RISK

Dr. Laurie Zabin investigated the risk of pregnancy according to how long the adolescent had been sexually active and found that half of premarital first pregnancies occurred in the first 6 months of sexual activity, 20 percent in the first month. She also found that nearly 20 percent of women who begin sexual activity become pregnant in the first 6 months--the younger the woman, the greater the risk. Ten percent of those under 15 at first exposure become pregnant in the first month. This is the result of very poor contraceptive practices--the younger the woman, the worse it is (19).

Youth is of little value in protecting against pregnancy for few engage in sex in the year or two following menarche, even those who begin sex at young ages (18). If the teen is not protected with any "natural immunity," what is her protection? Information? Teens who do not use contraception give a range of reasons: I'm too young; we don't have sex often enough; contraceptives are too difficult to get; it's the wrong time of the month. The last suggests a gross lack of information about the reproductive processes of the body. Only a minority of teenage women have a generally correct idea about the periodicity of fecundity. More whites than blacks, especially more of those whites who have had sex education (12), have a notion of the mechanics of the menstrual cycle. An analysis by Presser leads us to question whether the proportion with correct knowledge is even lower when one accounts

for guessing (20). If you do not think you are at risk, how can you take the next step--to protect against risk? In fact, many teens delay coming to a clinic for service, a serious error when the risk of conception is so high.

PREGNANCY--THE RESOLUTION

Teens do experience considerable numbers of unwanted pregnancies. In 1979, data for teens living in metropolitan areas indicate only 18 percent of those completing a pregnancy while unmarried wanted the pregnancy; moreover, only 32 percent of those not intending to become pregnant had used a contraceptive at the time they became pregnant (Table 7).

Table 7. Proportion of first unwanted premarital pregnancies by contraceptive use status: Percent 15-19 year-olds in metropolitan areas, 1971, 1976, and 1979

	1979	1976	1971
Pregnancy			
Not wanted	82.0	75.4	75.8
Used birth control	31.5	20.6	8.6
Did not use birth control	68.5	79.4	91.4

Source: Zelnik and Kantner (13).

Is it possible that teens do not care if they become pregnant? In 1979, about one-quarter never used contraceptives, and over one-third always did, clear improvements over previous years. Of those who were unmarried when a pregnancy ended, 37 percent chose induced abortion, an increase over previous years. There is ample evidence that teens are trying harder than ever to keep from reproducing at young ages but also continue to have problems with contraception. Interestingly, those choosing abortion have better contraceptive histories than non-aborters, supporting the view that abortion is regarded as a backup method. Between 1976 and 1979, teens tried harder and were less successful in preventing pregnancies. One reason may be their movement away from the pill and toward withdrawal. The pill may be viewed with concern, although medical risks are greater for older women, or it may be a difficult regimen to follow if sex is sporadic (13).

HEALTH CARE DELIVERY SYSTEMS

In-depth studies of teens associated with organized medical care systems point to the difficulties inherent in using them. Fear of a pelvic exam, uneasiness about the doctor's demeanor or simply fear that the doctor will be male, and fear of a breach of confidentiality all may delay a visit. Nervousness during a visit may preclude meaningful understanding of the complex information about their bodies, the contraceptive methods, and how to fit a method to their sex lives (21). The desire to stay away from the medical system may be coupled with a belief that drugstore methods are not effective enough to be worth the difficulties. But the bottom line is unmistakable. The present delivery systems are largely dependent upon the teen recognizing his/her need and seeking the service. The

teen, for a variety of reasons, is reluctant and delays. The result is a large number of unwanted pregnancies and abortions. The implicit solution is very difficult, for it presumes that the system will reach the adolescent before he or she is at risk, i.e., that it will come from parents, schools, and perhaps clinics that can serve those who are not yet sexually active (19). The challenge to overcome the difficulties is enormous.

It presumes that the generalized support for sex education in the schools can effectively function in local areas, that parents can be afforded opportunities to learn more about what and how and when to talk with their children, and that other systems can make major changes in their view of who their "target population" may be. It also presumes that no one seriously fears that talking about responsible sex encourages sex. Such a reorientation in the approach to the needs of adolescents is made all the more difficult because adolescents develop their interest in sex at different ages and messages about sex and reproduction may have to be delivered over and over.

Adolescent sexual and reproductive behavior is very complex and the problems occasioned by early involvement are challenging. We have only recently begun documenting those behaviors and seeking to systematically address the causes and consequences. While much remains to be learned, we have considerable information which can be marshalled to enlighten the discussion of the problems of adolescents and inform us about possible solutions.

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The Children of Teenage Parents

By Wendy Baldwin and Virginia S. Cain

Summary and Introduction

Teenage childbearing is associated with adverse, pervasive and long-lasting social and economic consequences for the young parents, especially adolescent mothers, who, at very young ages, also appear to be at higher risk of maternal morbidity and mortality.[1] Insofar as lower education and income and greater marital instability adversely affect the environment in which teenagers bring up their children, it might be expected that the life chances of their children would also be adversely affected. However, until recently, few studies have attempted to assess directly the impact of teenage parenthood on these children.[2] The relation of mother's age and child outcome can be viewed as the relation between becoming a mother as an adolescent and the outcome for subsequent children—regardless of the mother's age at their birth—or restricted to those children born while the woman is under age 20. This article addresses only the latter situation.

Recent research sheds light on the physical and developmental effects of teenage childbearing on the offspring. Most earlier studies highlighted the relationship of young maternal age with increased risk of low-birthweight babies and perinatal infant mortality.[3] The newer findings suggest that these phenomena are almost entirely functions of the quality of prenatal care received by the teenage mother. However, while excellent prenatal care of the teenager may result in the birth of a healthy infant, the subsequent health of her child may be severely jeopardized by early parenthood. All analyses show deficits in the cognitive development of children (especially male children) born to teenagers, much, but not all, of the effect results from the social and economic consequences of early childbearing. Less consistent effects are found for the children's social and emotional development and school adjustment. The children of teenage mothers are relatively likely to spend a considerable part of their childhood in one-parent households; and they are more likely themselves to have children while still adolescents. Adverse impacts can be observed long into the children's lives. A possible mediating factor between young maternal age and its impact on the child is family structure—that is, adverse effects are most likely to occur when the teenage mother raises her child without help from the father or her own parents.

This article is based on research conducted under the auspices of the Center for Population Research. The samples and methods employed in the individual studies are summarized in the appendix. The studies differ widely in terms of original purpose, measures available for analysis, age of the children when studied and racial, residential, economic and other characteristics of the sample. Data were collected at different times, and in two cases reflect the experiences of other countries. No one project may be viewed as definitive, but each makes a contribution to the delineation of how early childbearing affects the children of adolescent parents.

Children born to teenagers suffer intellectual deficits, largely because of the economic and social impact of early childbearing on the young parents. Such children are more likely to spend part of their childhood in one-parent households and to have children themselves while still adolescents.

Physical Health

Previous research has pointed out the apparent increase in risks to the mother's and baby's health as a result of the young age of the mother. This increase is noted especially

Table 1. Pregnancy outcome variable scores,* by mother's age,† Copenhagen, 1959–1961

Mother's age	Pregnancy complications (1)	Delivery complications (2)	Neonatal physical status (3)	One-year physical status (4)	One-year motor development (5)
10–15	2.43	4.84	3.98	7.12	2.45
16–17	3.68	5.38	4.73	7.79	2.45
18–19	3.39	5.30	4.91	9.65	2.39
20–24	4.09	5.97	5.57	8.25	2.69
25–29	4.85	6.48	5.70	9.47	3.07
30–34	4.88	6.72	5.79	8.40	3.10
35–39	5.06	6.79	5.98	7.81	3.08
≥40	5.72	7.39	6.32	7.46	3.68

*Score is a composite indicating both number and severity of problems; the higher the score, the worse the health status.

†Only those variables which vary systematically with mother's age are presented.

Source: See reference 4

Wendy Baldwin is Chief of the Social and Behavioral Sciences Branch, Center for Population Research, National Institute of Child Health and Human Development, DHHS. Virginia S. Cain is Psychologist with the Branch.

for second order and higher order births. Using data for the period 1950–1967, Helen Chase has shown that the percentage of babies who are of low birth weight (under 2,500 grams) is much higher for those born to adolescents, and higher as well for babies of black or other nonwhite mothers.[4] Jane Menken, reviewing an analysis of the 1960 U.S. birth cohort data, shows increased risk of infant mortality associated with young maternal ages, and some increased risk for children of mothers over age 40. Menken remarks, "Just after birth, when biologic factors related to the pregnancy are the primary determinants of survival, risks to infants of younger mothers are much higher than those to infants of older mothers in both color groups."[5] Such data have increased interest in unraveling the factors which tie maternal age to infant outcomes. Are many adolescents too biologically immature to produce healthy babies? Are inadequate prenatal care and nutrition among pregnant teenagers responsible for the risks observed?

Birgitte Mednick's study of 9,123 births in an urban Danish hospital around 1960 found that children born to younger mothers—including young adolescents—had lower rates of stillbirth and neonatal mortality than those born to older mothers, and that general indicators of health for both the mother and child in the perinatal period were also better (see Table 1, page 34, and Figure 1, page 36).[6] It is unlikely that differences in social class could explain this observation, since the adolescent mothers were from a lower socioeconomic group than were the older mothers. Also, since most teenagers in the catchment area were delivered in this program, it is unlikely that the program selected only teenagers highly motivated to get good prenatal care. These young women (aged 14 to 19) were drawn into a system of excellent prenatal care and, while apparently at high risk during pregnancy, had outcomes superior to those of older women.

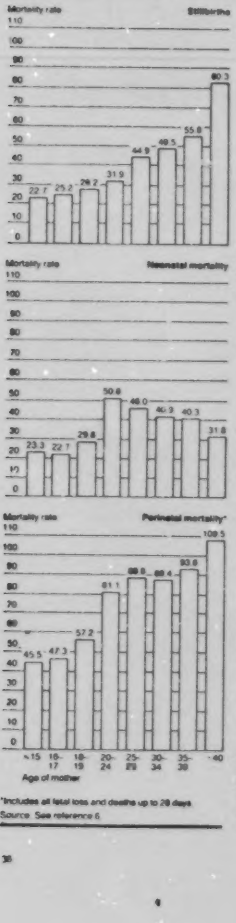
Is this finding unique? A study of American women found similar results when high-quality prenatal care was provided. The results of the Collaborative Perinatal Project (CPP) indicated that the perinatal mortality rates were lowest for the children of young white adolescents and increased with age of mother.[7] Howard Sandler also examined the relationship between mother's age and baby's health and behavior, based on 1974–1976 birth data from Nashville General Hospital, a county hospital serving primarily low-income patients.[8] Mothers between the ages of 13 and 39 were categorized into 12 age-groups ranging from 13–14-year-olds to 35–39-year-olds. As may be seen in Table 2 (page 36), no consistent or significant differences in neonatal outcomes were found between age-groups.* Next, the behavioral characteristics of the infants of adolescent mothers were compared with those of older mothers. Table 3 (page 37) shows Brazelton scores, which are social and neurological assessments taken two days after birth, for children of adolescent and postadolescent mothers. Again, when the quality of medical care was maintained, babies born to adolescents did as well as babies born to older mothers. This study does not, however, show that adolescent obstetric patients fare better than older mothers. Younger adolescent women, pregnant for the first time, experienced more stress during pregnancy than did older women, regardless of parity (not shown).†

A study by Barry Lester also focused on Brazelton scores and found that babies of teenage mothers tested two days after birth were significantly more likely to be underaroused or overaroused than babies of older mothers; these differences were found in both a Florida and a Puerto Rico sample. Although the Brazelton scores of the babies of teenage mothers fell within the normal range, Lester emphasizes that these infants could face serious problems in the future. This is because of the likelihood that the stress of teenage motherhood could affect the interaction between mother and child so as to exaggerate the differences found soon after birth. Both samples were drawn from low-income populations.[9] Sixty-six percent of the adolescent mothers in the Florida group were unmarried, and most were black, while only nine percent were unmarried in the Puerto Rico sample of whites. In Florida, obstetric risk scores were higher for babies born of teenage mothers; this was not the case in Puerto Rico. Lester concludes that "analysis of Brazelton scores showed that when teenage mothers were matched for obstetric history and perinatal risk factors and further divided into high and low obstetric risk groups, infants of teenage mothers show scores comparable to infants of older mothers." Age of mother did not have an independent effect on behavioral outcomes. Obstetric risk was viewed as a function of the environment in which adolescent childbearing took place rather than as a function of age per se. Thus, the differences between the find-

*Some of these age groups were combined for presentation in Table 2.

†This study has shown length of labor and parity to be related to drug dosage given prior to delivery. Primiparous women and women experiencing a long period of labor received stronger and larger doses of drugs. But as adolescents are likely to be both primiparous and in labor for a shorter period of time, the relationship between predelivery drug usage and age of mother is unclear. However, a clear relationship exists between the mother's usage of drugs and the infant's behavior. The usage and timing of such drugs is subsequently related to decrements on Brazelton scores. Drug dosage should be considered as a strong the effect of maternal characteristics on neonatal behavior.

Figure 1. Stillbirth, neonatal and perinatal infant mortality rates per 1,000 births, by age of mother, Copenhagen, 1959–1961



*Includes all fetal loss and deaths up to 28 days

Source: See reference 6.

ings for Florida and Puerto Rico could be due to the different sociocultural contexts in which childbearing occurred. In Puerto Rico, where early marriage and childbearing are accepted as part of normal adolescent development within this socioeconomic group, teenage mothers are likely to experience less stress. Other studies of adolescent pregnancy and delivery outcome have also suggested that problems associated with adolescent pregnancy may be due to factors other than mother's age, particularly, the quality of prenatal care.[9]

These studies all point to the heavy influence of nonbiological factors—especially the quality of prenatal care—on the relationship between mother's age and risk to the newborn. While encouraging the development of programs to provide such care, this research does not tell us what is the minimum increment in prenatal care programs that is needed, whether urban university-based programs can be translated to suburban or rural environments, what is the cost of such services in a variety of environments and whether taxpayers and policy-makers would view these expenses as cost-effective.

A corollary to the question of cost-effectiveness is the long-term impact of adolescent childbearing, even when perinatal risks are reduced. Both the Sandler and Mednick studies followed children longitudinally and found a somewhat different picture when later health status was assessed. The Danish data showed that at one year of age the children of adolescents did not fare worse than children of mothers in their 20s (see columns 4 and 5, Table 1), but that this relationship was strongly influenced by family structure. The babies of adolescent mothers who were raising the child alone were clearly worse off in terms of their physical health status score (mean 9.2) than those raised by the teenage mother and father (mean score 8.5) or the teenage mother and grandmother (7.6).[11] Sandler found an effect of mother's age on the mother-infant interaction observed at one, three, six and 12 months of the child's age. The older mothers spent more time talking to and looking at their babies than did the younger mothers and these positive social interactions between the mother and child were associated with higher scores on tests of the baby's motor and mental development at nine months (not shown).

Both studies point to the influence of the mother's age on the child's early development as transmitted through the environment. The Danish data show young maternal age, given high quality prenatal care, to be a benefit in terms of perinatal outcome. This early advantage is only maintained at one year, however, when the social environment is optimal. The Tennessee data show differences in the ways teenage and older mothers behave with their babies and differences in child development at later stages even when perinatal outcome has been good.

Cognitive Development

Two other studies focus on whether there is a lasting effect of a child's cognitive development associated with the mother's age at birth. Jeanne Marecek found babies of black urban adolescent mothers to be slightly less well off when their development was measured by the Bayley Scales of Infant De-

Table 2. Mean physiological characteristics of infants, by mother's age, Nashville, 1974–1977

Mother's age	Birth weight (kg)	Birth length (cm)	Apgar 1-minute	Apgar 5-minute
13–14	3.05	49.33	7.00	8.33
15–16	3.19	50.52	8.07	9.62
17–18	3.10	49.47	8.12	9.65
19–20	3.11	49.29	8.43	9.49
21–24	3.19	50.28	7.77	9.49
25–39	3.01	49.71	8.02	10.00

Source: See reference 8.

velopment (at eight months of age), the Stanford-Binet test (at age six) and the Wechsler Intelligence Scale for Children (WISC) and Wide Range Achievement Tests (at age seven).[12] A similar pattern was found by Joy Dryfoos and Lillian Belmont using the total Collaborative Perinatal Project (CPP) data file and studying only seven-year-olds (see Table 4).[13] Regression analyses by Dryfoos and Belmont based on the Health Examination Survey (HES) data confirm small but significant effects of maternal age on IQ and also show a persistence of this effect over the three and one-half years between tests.

A study conducted by Frank Furstenberg in Baltimore included an assessment of preparation for school, the Preschool Inventory (PSI), among children aged 42–69 months.[14] The sample was composed primarily of children of urban, low-income, black adolescents. The children's scores, standardized for the child's age, were somewhat lower than the scores of the children of a sample of the adolescents' classmates who began childbearing at a later age, and were considerably lower than groups of middle-class black and white children and working-class white children. Within the sample of children of adolescent mothers, no relationship was found between mother's age and child's cognitive

development. Children of mothers younger than 16 did as well as those of mothers aged 16–18. The amount of time the mother spent with the child was inversely related to the child's PSI score. The children of unmarried mothers who were not employed scored lower than those whose mothers worked outside of the home or were continuing their education, thus sharing the childrearing responsibilities with another adult. Generally, the working mothers and mothers attending school were economically advantaged when compared to the mothers who were not employed. In this study, as in others, the socioeconomic status of the mother was closely linked to her child's cognitive test scores. A further explanation, also suggested by other research, is that the child benefits from having an older, more experienced caretaker. Generally, the caretaker is the child's grandmother or other close relative who is likely to be concerned about the child's development and to provide more than just custodial care. Such an arrangement also provides at least two adult figures with whom the child has contact. The positive influence of more than one caretaker on the child's development is borne out by the finding that the children of mothers who married the child's father, and remained married during the study period, scored higher than children in other family situations. However, children whose mothers were unmarried and were working or going to school (who, therefore, had other caretakers besides their mothers) did nearly as well as the children of married mothers.

In sum, various analyses show a considerable relationship between a mother's age and her child's cognitive development. When background characteristics are controlled, a significant effect remains which is to the disadvantage of the children of adolescents. While statistically significant, the effect on measures of aptitude is small and may be trivial in terms of later achievement.

Social-Emotional Development

The relationship between mother's age and her child's social and emotional development is less well-defined than the relationship between age and cognitive development. Furstenberg used doll-play to measure efficacy, trust, self-esteem and ability to delay gratification among children aged 43–80 months; he found no major or consistent effect of having been born to an adolescent mother. When differences between subgroups of the adolescent sample were analyzed, however, a pattern did emerge. Children of mothers who married the child's father and remained married to him scored higher on the social-emotional development measures than other children. Initially, it was thought that the ability of the father and the child to maintain a stable relationship was the key factor in the child's development. However, among the children who did not reside with their fathers, the amount of father's involvement was not related to the child's scores. Additional analyses indicated that children of economically secure families scored higher on the efficacy and trust measures. This finding held true within the single-parent families. Children of unmarried mothers who completed high school and were not on welfare scored higher than more economically disadvantaged children. Furstenberg's study suggests that the factor in the intact families which influenced the child's social and emotional development was the economic advantage afforded by the two-parent household. Parents in these households were generally better educated and more regularly employed.

Marecek focused on the social and emotional behavior of children when the children were four and seven years of age.[15] The CPP data included measures of the child's interactions with a psychological tester who was administering IQ tests, as well as reports from the child's primary caretaker concerning the child's behavior at home. Maternal age had little effect on the child's behavior at age four, but by age seven a number of effects were found. Children born to mothers younger than 18 exhibited greater overactivity, hostility, restlessness and lack of impulse control. Dryfoos and Belmont, using Cycle II of the Health Examination Surveys, however, found no relationship between mother's age and child's social and emotional behavior.[8]

Overall, the effect of the mother's age on her child's social and emotional development is not as clear as it is on her child's cognitive development. It does seem that when an effect of young maternal age was present, it was negative and often was not evident until the child was nearing school age. Again, evidence suggests that the effect does not result from the mother's age at birth directly, but rather is transmitted through other factors associated with early childbearing, such as educational and economic disadvantage and greater likelihood of marital breakup.

School Achievement

Considering that the children of adolescent mothers are generally found to have lower IQ scores and, possibly, greater social adjustment problems, what is the likelihood that such children will be successful in school, which requires both intellectual achievement and social adjustment? Two studies have examined children's success in school. Kingsley Davis and Amyra S. Grossbard, using a subsample from the HES Cycle II data, studied 10- and 11-year-olds from intact families. Within the group of teenage mothers, financially disadvantaged children did significantly more poorly in school, as measured by grade repetition and reading scores, than those more economically secure.[7]

Sheppard Kellam, in his longitudinal study of 1,242 children and their families in a low-income, urban, black community, found that the children (who entered school in 1966) who were born to mothers 17 years old

Table 3. Mean Infant's Brazelton Neonatal Behavioral Assessment Score, by mother's age, Nashville, 1976–1977

Brazelton Scale	Mother's age	
	13–19.5	19.6–39
Initial state	2.53	2.48
Predominant state 1	4.08	4.21
Predominant state 2	4.77	4.86
Interactive processes	2.31	2.39
Motoric processes	1.80	1.87
Organizational processes: state control	2.10	2.09
Organizational processes: physiological response to stress	1.87	1.83

Note: Scores on the first three items of the scale range from (1) deep sleep, to (3) moderate activity to still crying; initial state refers to the period two minutes before administration of the infant is begun, the predominant states refer to the periods during examination and stimulation of the infant. For the last four items on the scale, a normal score is 2.

Source: J. McLaughlin, H. Sandler, K. Sherrod, P. Vietze and S. O'Connor, "Social-Psychological Characteristics of Adolescent Mothers and Behavioral Characteristics of the First-Born Infants," paper presented at NICHD workshop, Bethesda, Md., Jan. 1979.

Table 4. Mean Wechsler Intelligence Scale for Children (WISC) full-scale IQ, for the Health Examination Survey (HES) and Collaborative Perinatal Project (CPP), by mother's age at birth of index child

Mother's age	HES		CPP
	Cycle II (ages 6–11)	Cycle III (ages 12–17)	(age 7)
14–17	94.41	91.48*	90.98
18–19	95.58	97.07	94.44
20–24	98.75	100.63	97.09
25–29	101.97	101.29	97.31
30–34	102.33	102.16	98.39
35–39	102.97	100.82	99.75
40–44	99.39	100.43	98.59
7–45	99.30	99.26	97.38

*Cycle III mean excludes two cases with mothers aged 12 years.

Note: For description of HES and CPP, see appendix, p. 40.

Source: See references 13.

or younger were less likely to adapt to school, as rated by their first-grade teachers, than were children born to older mothers.[18] When measures were taken 10 years later, mother's age at birth was not found to have a direct effect on the 16-year-old children's psychiatric symptom rating. However, failure to adapt to school at age six was strongly related to more intense psychiatric symptoms as a teenager. Thus, adolescent childbearing appears to affect the child's teenage emotional adjustment indirectly through its effect on early adaptation to school. As in the Mednick and Furstenberg studies, the negative effect of having an adolescent mother was ameliorated by the presence of either a father or a grandmother in addition to the mother in the household.[19]

An unanticipated result of Kellam's and one other investigator's research was a differential effect of young maternal age on the cognitive and emotional development of male and female children. Kellam's finding that first-grade adaptation problems were associated with psychiatric symptoms 10 years later was particularly strong for boys.[20]

Marecek's analysis of Stanford-Binet IQ scores for four-year-old black children found no effect of young maternal age on girls' scores, but a marginally significant effect on boys' scores.[21] Further evidence of this trend was found in the WISC scores of the seven-year-old black children, where differences between the effects on male children and on female children reached statistical significance. Separate analyses of the verbal and performance scores indicated that age of mother was related to both verbal and performance scores among boys but only to verbal IQ among girls (see Table 5).

Lasting Effects

A study by Josefina J. Card, based on the Project TALENT data (a longitudinal national survey of 375,000 teenagers in grades 9–12 in 1960) looked at educational, occupational and social differences between children born to adolescent mothers and children born to older mothers.[22] This analysis showed a number of differences that were the result of different social and economic characteristics of children of younger as compared to older mothers. Even with these factors controlled, the children of younger mothers showed decrements in terms of cognitive development, were more likely to live in one-parent homes and also showed more early childbearing themselves as compared to children of older mothers.

In a longitudinal study of a representative sample of mothers in three boroughs of New York City, Harriet Presser assessed the social and demographic consequences of a woman's having a first birth during her teenage years versus postponing it until she is in her 20s.[23] Presser found the best predictor of an adolescent first birth was the subject's mother's age at first birth. That is, the child of a teenage mother was at relatively high risk of becoming a teenage mother herself.

Marital Disruption

The studies cited earlier suggest that the long-term health, cognitive and social and emotional development of the children of teenage mothers was improved if the child was brought up in a household with more than one parent. Do the children of teenage parents have a relatively high risk of spending a considerable part of their childhood in one-parent households?

More than four in 10 adolescent mothers are unmarried; and among those who marry, separation and divorce rates are high. Many unwed teenage mothers marry soon after the birth. But these marriages, too, suffer high rates of disruption, and the relationship of young age at first marriage and an increased risk of divorce or separation persists into second marriages. Jane Menken and James McCarthy have analyzed the 1973 National Survey of Family Growth, a national probability sample of women aged 15–44 who were ever married or were single and living with at least one of their natural children.[24] They found that the younger the mother at the time of her first birth, the greater the likelihood that the child will spend at least some of the years up to age eight in a single-parent (i.e., mother-alone) household. Children born to young mothers are much more likely to be born out of wedlock than those born to older women, and first-born children are more often born out of wedlock than are those born later. Also, the likelihood of being born out of wedlock is much higher for black than for white children. This life-table analysis was done separately for the periods 1965–1969 and 1970–1973, it shows that for the earlier period, 32 percent of first-born children of white women younger than 18 had lived in a single-parent household by age two, and by age eight the proportion had risen to 59 percent (see Table 6). The likelihood of ever residing in a single-parent family was considerably greater for black than for white children. Some researchers are making special efforts to analyze patterns of family structure. Such patterns are extremely complex, and extend far beyond the definition of families as intact or not. (For example, Kellam found 86 different combinations of adults in his 1967 family interviews with mothers or mother-surrogates of first-grade children.[25]) Recognition of this complexity is especially important if, in fact, a key issue is whether the mother is alone or not. Clearly, many nonintact families include other adults. Kellam's longitudinal analysis showed that when the study child was in first grade, mothers who had begun childbearing as teenagers were more likely to be living in mother-alone families than were older mothers. Interestingly, if the study child was a first-born, there was no difference in the likelihood of the mother living at home with no other adults, but the other adult was likely to be the maternal grandmother for the teenage mothers and the child's father for the older mothers. In this study, teenage mothers who had two children were at the greatest risk of living in homes where there were no other adults. Whether this was because the grandparents were unable to accommodate a daughter and her two children, or because of a preference on the part of mothers of two to live alone, is not answered.

There were strikingly different patterns of marital stability over time. Married teenage mothers were twice as likely to separate or divorce as were those who gave birth in their 20s. If a marital disruption occurred, the father was likely to leave earlier in the child's life if the mother gave birth as a teenager than if she were older. The effects of early motherhood on the child continued into the teens: The child of a postadolescent mother was more likely at age 16 to be living in a mother-father household (or in a household with the mother and another adult) than was

Table 5. Mean WISC scores for 7-year-old black children in Philadelphia CPP sample, by sex of child and mother's age at first birth

Mother's age	WISC score					
	Full-scale IQ		Verbal IQ		Performance IQ	
	Male	Female	Male	Female	Male	Female
<18	87.7	88.3	87.3	87.6	90.5	93.0
18–19	90.2	92.2	88.7	90.4	93.7	95.5
20–25	92.1	90.6	90.4	88.1	96.4	94.0

Source: See reference 12.

the child of an adolescent mother. Refusal rates for the second interview were higher among adolescents than nonadolescents—possibly part of their pattern of less participation in social organizations—and so these observations should be taken as suggestive of future research directions on the evolution of family structure. Many other studies have documented the high rates of disruption of teenage marriages.[26] Prasser found that 34 percent of the 15–19-year-old mothers who were married before the birth of their first child were separated or divorced by the time of the third interview, when the child was between four and six years old.[27]

Table 6. Percentage of first-born children living in single-parent households, by mother's race and age at child's birth, and child's age, 1968–1988

Child's age	Mother's race and age			
	White		Black	
	<18	>35	<18	>35
2	32	6	85	42
6	69	11	92	48

Source: See reference 23.

Conclusion

There is an intriguing pattern of relationship of adolescent childbearing to child development. Previous debates on the role of biological and environmental factors, especially prenatal care, have not been totally resolved, but the evidence is strong for the predominant influence of prenatal care on neonatal outcome. The fact that some programs show no negative effect—and even some positive effect—of young age is persuasive, but raises additional research and policy issues involving the level and cost of prenatal care required to compensate for the high risk involved in early childbearing. Studies that show decrements in infant health after the neonatal period urge us to look at the context of childrearing. Research on the role of family structure strongly suggests that the presence of adults other than the young mother in some way mitigates the deleterious health and other effects on the child associated with teenage childbearing. These findings suggest the need to elaborate better the division of child-care responsibility, the role of support networks and other interpersonal resources available to the young mother and her child. Present research has not dealt with the interrelationships of maternal characteristics and the availability and use of familial supports; we need to know more about why some adolescent mothers have familial or other supports available, and why some choose to accept these resources and others do not. The Family Impact Seminar has elaborated on many of these issues in its report *Teenage Pregnancy and Family Impact*.[28]

The effects of adolescent motherhood are observed in their children over many years; such long-term effects are consistent with findings from research on the effects of early childbearing on the teenage mother. These effects are persistent and color the general atmosphere in which a child develops: reduced education and occupational attainment of the mother, increased welfare dependency, higher fertility and marital disruption.[29] Higher rates of marital instability result in significantly larger proportions of time spent in one-parent families for the children of adolescent mothers than for the children of older mothers.

Research on the children of teenage mothers has focused on the effects on cognitive development, in part because of the availability of data. These effects, while statistically significant, are not startlingly large; but they, too, are persistent. The apparent relationship of early childbearing of the mother with early childbearing of her offspring is disturbing since it implies some generational effect. Do the large numbers of births to adolescents in recent years mean future waves of early childbearing? No one knows for sure, especially since there is little evidence to speak to the effects of intervention programs.

These data do not suggest that meliorative programs should focus directly on the children of teenage parents. Most of the observed adverse consequences to the children appear to result from the truncated education, and the poor employment and marriage prospects of the teenage mother. The research presented here, while not specifically evaluating service programs, suggests that one way to help the children of adolescents is to improve the educational and employment opportunities of the teenage parents and to encourage the supporting role of other adult family members.

Do these diverse studies fit into a coherent picture? They strongly support the view that there are effects of early motherhood on some important areas of early child development. They offer no support for a biological model of explanation of these effects; rather, the avenues through which effects are likely to operate are social and economic. The role of family structure is apparently an important one. These studies were not begun to study family structure nor, in most cases, to study adolescent childbearing, but the findings are consistent, conceptually sound and empirically compelling. They answer many questions, but raise many more. Not the least of these questions is whether researchers will look further at the interrelationship of personal characteristics of the mother and the role of family structure, and at the influence of public policy and social programs on the family careers of young mothers.

In the coming years we are likely to see a reduction in the number of births to adolescents, given declining birthrates and numbers of teenagers. This slackening in the numbers of people involved in adolescent childbearing should give us some time to advance our knowledge base and develop thoughtful social policies and service programs. It would be most unfortunate if we lost sight of the babies born to adolescents in the past decade who will be reaching childbearing age in the next decade.

Good prenatal care can cut the risk of prematurity among babies of teenage mothers.

Appendix

The studies reported here have all received support from the Center for Population Research, NICHD. Detailed final reports of these studies will be available when the projects are completed. A brief description of each follows:

• **Birgitte Modrick** of the University of Southern California is studying the consequences of family structure for the child's and the mother's development using data from the Danish Longitudinal Perinatal study. The 9,125 subjects included in the study were drawn from a Danish birth cohort including all deliveries taking place at the State University Hospital, Rigshospitalet, in Copenhagen within a two-year period from

(Continued on page 43)

(Continued from page 39)

1959 to 1961. The mothers and the children were subjected to regular and thorough medical examinations during pregnancy and the first year of the child's life. A variety of subsequent outcome measures are available for a subsample of the original subjects.

• **Howard Sandler** of George Peabody College has studied the effects of adolescent pregnancy on mother-infant relationships. Data were collected at the Nashville General Hospital, the county hospital for the indigent, between 1974 and 1977. Information for this study is available for women aged 13–39 and their children. Data were collected prenatally for 85 percent of the sample, and the children of adolescent mothers (aged 14–19) in their first pregnancy were compared with the children of older mothers (aged 20–26) on a variety of measures taken during the neonatal state. In addition, a prospective study of child abuse and neglect provided extensive measures of the mothers' experience with life stress and adjustments to stress. This subproject included observational data on interaction between mother and child at one, three, six and 12 months following birth.

• **Barry Lester** of Children's Hospital Medical Center, Boston, carried out a study of the relationship between teenage pregnancy and neonatal behavior. In this study, the principal measure of behavior is the Brazelton Neonatal Behavioral Assessment Scale applied to two-day-old infants. The study population comprises two groups: 1) 153 babies born at the Shads Teaching Hospital, University of Florida Medical School, and 2) 156 babies born at the Hospital Municipal, San Juan, Puerto Rico. In addition to the Brazelton Scale, complete medical histories of mother and baby, birth weight, and one- and five-minute Apgar scores are available for each infant. A total of 311 babies were studied, 62 of them born to women under age 18. The mothers had low incomes, and the Florida mothers were part of a medical care program for the indigent.

• Several studies used two large national data bases or subsets of those data bases. One source was the Collaborative Perinatal Project (CPP), supported by the National Institute of Neurological Diseases and Stroke, National Institutes of Health. The purpose of the CPP was to define parameters of fetal wastage, assess etiological factors and identify areas for further research or intervention. Fifteen medical centers participated, all university-affiliated, and data were collected on almost 56,000 pregnancies, beginning in 1959. Follow-up extended to age seven for the index child.* A second source was The Health Examination Surveys (HES), supported by the National Center for Health Statistics (NCHS). Data were collected at 40 locations across the United States on the physical and psychological characteristics of the civilian noninstitutionalized population in several nationwide surveys. The initial phase of the project, Cycle I, examined adults. Cycle II includes data on 7,119 children between the ages of six and 11 during 1963–1965. Cycle III provides data on 6,765 youths between the ages of 12 and 17 in 1966–1970. Further descriptions of the Surveys can be found in NCHS publications (Series 1).

Early adaptation to school may be more difficult for children of teenage mothers.

Jeanne Harcock of the Institute for the Continuous Study of Man examined the consequences of teen childbearing in a low-income, predominantly black, urban population. The data base was the Philadelphia CPP. Intellectual development was measured at eight months by the Bayley Scales of Infant Development, at four years by the Stanford-Binet and at seven years by the Wechsler Intelligence Scale for Children (WISC). Behavioral profiles were completed by the CPP testers at eight months, four and seven years. The scholastic achievement of the seven-year-olds was measured by the Wide Range Achievement Test.

A study by **Joy Dryfoos** of The Alan Guttmacher Institute and **Lillian Belmont** of Columbia University focused on the differences with respect to intelligence, achievement and personality adjustment between children of youthful mothers and other children of the same age. This study makes use of Cycles II and III of the HES and total CPP data on children seven years old. Measures of intellectual development and achievement included the Goodenough Draw-a-Person Test and the Wide Range Achievement Test. Social and emotional development were assessed by responses to a parent's questionnaire and responses to a questionnaire administered to the child which contained many of the same items. Behavioral observations were also made by the psychologist administering the tests. A final measure of the social and emotional development of the child was based on school problems as reported by the school.

A study by **Kingsley Davis** and **Amyra Shachtman Grossbard** of the University of Southern California examined the relationship between mother's age and child's intellectual development and school performance using the Cycle II HES data. A subsample of 1,730 10- and 11-year-old boys and girls from families with both parents present was selected. Cycle II contains data on children's intellectual development as measured by the Vocabulary and Block Design subtests of the WISC and school performance as measured by grade repetition and reading scores.

• **Shoppard Kellam** of the University of Chicago studied the social, psychological and psychiatric consequences, over time, of teenage childbearing for the teenage mother, the children born to teenage mothers, and families containing women who began

*See reference 7.

childbearing as teenagers. The project analyzed data collected for the Social Psychiatry Study Center's longitudinal community-wide study of children (ages 6–16) and their families in a black, urban, low-income Chicago community. The study sample consisted of 1,242 children who entered the first grade in 1966, over 200 of whom were born to teenage mothers. Over 500 of the mothers in the study began childbearing as teenagers.

• **Frank F. Furstenberg, Jr.**, of the University of Pennsylvania, in a longitudinal study of unmarried teenage mothers living in Baltimore (funded by the Maternal and Child Health Service of DHEW), investigated the relationship of young maternal age to children's cognitive, social and emotional development. Interviews were conducted during 1966–1968 with 404 mothers under 18 years old who were pregnant for the first time. Follow-up interviews were conducted with the mothers at one year, three years and five years after delivery. For comparison, classmates of the adolescent mothers were also interviewed at the three- and five-year follow-up. Interviews were conducted with the children of the study mothers and their classmates at the five-year follow-up. The children's cognitive development was measured by the Preschool Inventory, a test of school readiness; social-emotional development was assessed through doll play designed to tap efficacy, trust, self-esteem and ability to defer gratification.

• In an analysis of Project TALENT data, **Josefina J. Card** of the American Institutes for Research (AIR) studied the long-term consequences of early childbearing for adolescent mothers and their children. In 1960, TALENT, an AIR project sponsored by DHEW's Office of Education, gathered extensive demographic, cognitive and socio-psychological data from a nationwide sample of 375,000 students in grade 9–12. The progress of the personal and professional lives of a sample of these individuals was followed at one, five and 11 years after the date of their expected high school graduation, when they were approximately 19, 23 and 29 years old. Follow-up data from TALENT participants who gave birth as teenagers were compared with similar data from participants who postponed childbearing until their 20s or later.

• In a longitudinal study of mothers in three boroughs of New York City, **Harriet Presser** of the University of Maryland assessed the sociological and demographic consequences of a woman's having a first birth during her teenage years versus postponing it until her 20s. The population from which the sample was drawn was stratified by mother's age, marital status and race to assure a distribution for the sample that was representative of the three New York City boroughs.

• **Jane Menken** of the Office of Population Research, Princeton University, and **James McCarthy** of the Department of Population Dynamics, The Johns Hopkins University School of Hygiene and Public Health, studied the household contexts in which children spend their lives up to age 18, focusing on the differences in family structure between the families of children born to teenage mothers and those of children born to older mothers. Data were taken from Cycle I (1973) of the National Survey of Family Growth (NSFG) conducted by the National Center for Health Statistics. The NSFG sample was composed of 9,797 women, of whom 3,856 were black, 5,864 were white and 77 were of other races. To be eligible, a woman had to be between the ages of 15 and 44 at the time of the interview and either married at least once or never married but raising a natural child. The NSFG was designed to provide information about fertility, family planning intentions and activity and other aspects of maternal and child health closely related to childbearing. Complete marriage histories are available for the women.

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Mr. LEHMAN. Thank you very much.

We would at this time like to welcome aboard the chairman of the full select committee, Hon. George Miller. If you have a statement, George, at this time, we would certainly like to hear it.

Chairman MILLER. Thank you, Congressman Lehman. This second meeting of the Prevention Strategies Task Force focuses correctly on one of the most important and troubling issues confronting this committee: the problem of teenage pregnancy.

As the first report of the select committee noted, out-of-wedlock births have increased dramatically in the last decade. Over one-half million of these children are born to teenagers, many of whom are unmarried. The chances are far higher than average that their infants will be at medical risk, that they will be born into poverty, and that their parents will lack the financial or educational resources necessary to assure them the quality of life that any one of us would want for our own children.

We are going to concentrate this morning on gathering the full facts on teenage pregnancy. Any discussion of teenage pregnancy and parenthood must also involve a discussion of education, job training, welfare, nutrition, and medical care.

We have brought together the experts who can address these serious issues with their research findings. I am looking forward to taking an in depth look at the scope and dimensions of the problem, the consequences for young teens, their children, and society, as well as some prevention strategies which have worked.

Mr. LEHMAN. All right. If Congressman Weiss or Congresswoman Schroeder has a statement, we would be happy to hear it.

Mr. WEISS. I have no statement, Mr. Chairman.

Mr. LEHMAN. I have several questions that I would like to submit for the record, without objection. I just want to ask a question about not just teenage pregnancy, but teenage sexual activity. How hard is this data—I guess it is gathered by questionnaire——

Dr. BALDWIN. Yes.

Mr. LEHMAN. When you talk to teenagers about sexual activity, are you really relating to actual sexual intercourse, and only sexual intercourse? Can it be interpreted as only sexual intercourse? There are various forms of sexual activity, as you know, that are not necessarily conducive to pregnancy.

Dr. BALDWIN. True. The data on sexual activity come primarily from three surveys that were conducted in the United States. These were conducted with large numbers of adolescents, 2,000 to 4,000, depending on the survey. They are done by professional survey organizations, and they include questions on whether the adolescent has had sexual intercourse. The interviewer is provided, of course, with a list of alternative ways of expressing this so that she is sure that——

Mr. LEHMAN. That they are talking about——

Dr. BALDWIN [continuing]. They understand what the question is. That is a question that is extensively pre-tested to make sure that it is understood by teenagers. In different parts of the country, words mean different things. Interviewers are instructed so that whatever answer they get, they can tell what it means and how to classify it.

I am pretty confident about how the data that we have on sexual activity are collected. They are consistent across surveys. In addition, there are other checks that make sure sexual activity fits with other behavior.

Mr. LEHMAN. With this increase in sexual activity, how soon do you think we should do something or undertake some activity to prevent this teenage sexual activity, and what have you seen that is effective in reducing teenage sexual activity?

Dr. BALDWIN. In reducing teenage sexual activity?

Mr. LEHMAN. What can we do—we know the more available we make birth control devices, apparently there is more sexual activity. Is there a correlation between the availability of birth control devices and teenage sexual activity?

Dr. BALDWIN. Well, I really do not think so, although it is difficult to have exactly the right study that shows you when things happen and the sequence of events. But teens delay considerably coming into family planning clinics.

Teens make one set of decisions revolving around being sexually active. That decision is related to a number of things that have virtually nothing to do with the clinics. They revolve around the stability of the relationship with the partner, their feelings of maturity, their sense of whether sex is something they want to wait until marriage for. A lot of teens who are not sexually active, look a lot like the ones who are in terms of their values and beliefs, but the former have just not found the right person yet.

There are very strong interpersonal factors that influence the initiation of sex. Most teens have a long delay before that relationship is established and they start thinking of themselves as being in need of contraception.

Mr. LEHMAN. Is the sixth grade too late to start counseling?

Dr. BALDWIN. It is difficult to pick a specific age to begin sex education. My view is that there needs to be an ongoing process of providing children with information about their bodies, about interpersonal relationships, about their abilities and what life holds for them. Sometimes the needs are for explicitly sex-related information, sometimes the needs are for more general information and guidance. By the time children are in the sixth grade, a few will be sexually active, many will be ready for sex-related information, and others will be years away from interest in sex.

Mr. LEHMAN. You have answered my question.

Two other quick questions. Who are the best people to counsel? I know of a program where a 19-year-old peer group—not peer group—19-year-old mothers who have had three or four children sometimes make the best counselors. Have you seen any programs in effect that way?

Dr. BALDWIN. There have been many studies of peer counseling; unfortunately, although the program has been tried and found to be successful, no long-term evaluations are available. This is because such programs may exist for 1 year or 2 and are then terminated, often for lack of funding. In any case, peer counseling was not intended to be, nor should it be, a substitute for a basic sex education curriculum in the schools; rather, it does serve as a supplement to such programs.

Mr. LEHMAN. I would like to see more of that happen.

One last question. The "squeal rule." Do you think that, in your opinion, a pharmacist or whoever provides, a young woman, a teenager, with birth control devices should be required to notify the parents?

Dr. BALDWIN. That is a very difficult question. [Laughter.]

Mr. LEHMAN. Or for that matter, the teenaged boy.

Dr. BALDWIN. Well, certainly, if it were going to be a policy, it should apply equally to boys and girls.

Mr. LEHMAN. Do you think that our society would be benefited if the person from whom the teenager is buying a birth-control device should be required to notify that child's parents?

Dr. BALDWIN. Let me go back to some research that does reflect on that. About half of these unwanted pregnancies occur very shortly after teens become sexually active. In many cases, this is before they have made any attempt to seek out contraception. So from my view, the main thing we have to think about are ways of reaching adolescents before they define themselves as in need of contraception.

You are talking about a situation where the teen has already said, "I need contraception." But the research shows us that the big area that we need to focus on is getting to the teens and helping them before they identify themselves as being in need of contraception and seeking out a service. That is a much harder challenge.

Mr. LEHMAN. Do you have a daughter?

Dr. BALDWIN. Yes, I do.

Mr. LEHMAN. How old is she?

Dr. BALDWIN. Well, she is six.

Mr. LEHMAN. When she gets to be 14 or 15, do you—if she were seeking a birth-control device, would you want the person that she sought the birth-control device from to notify you?

Dr. BALDWIN. My personal feeling is that sex education is an ongoing process that should begin very early. A parent has had many opportunities to provide guidance before a child becomes sexually active.

Mr. LEHMAN. I did not mean to make this too personal, but I meant to make it sort of an abstract example. I think you have answered the question. I am sorry I took so much time, and I hope I did not exceed what I hope will be a 5-minute rule for the rest of the members. [Laughter.]

Mr. LEHMAN. I yield to Mr. Bliley, the ranking member.

Mr. BLILEY. Thank you, Mr. Chairman.

I am surprised in your testimony that more mention was not made of adoption when we discussed adolescent pregnancy. Has the National Institute of Child Health and Human Development done any national studies on the practice of adoption and the well-being of adopted babies?

Dr. BALDWIN. No; indirectly we have, in that the studies that I have reported on about adolescents do ask whether the adolescent has had a child and where that child is now, thus generating information on whether or not that child has been adopted.

I do not think that takes the place of the kind of comprehensive national study that many of us would like to see on adoption. Adoption statistics are in disarray. They have not been collected at

a national level for many years. Of course, there are a great number of problems in collecting a set of national figures on the numbers of babies available for adoption and placed for adoption and what their characteristics are.

The last data we have are from the early 1970's. They show about 150,000 babies adopted; 50 to 60 percent of those were born out of wedlock, but we have virtually no data after that period.

The national survey data show that, in 1971, 2 percent of the black teenagers who said they had an out-of-wedlock birth said they had placed the child for adoption and 18 percent of the white girls did. By 1976, only 7 percent of the whites reported having placed a child for adoption, and in this survey, none of the blacks did.

Now, those data are consistent with other bits of data that we have from other places, which is that adoption has diminished in frequency over the last decade; that it is more prevalent among whites than among blacks; and that it is not very prevalent among either group.

Mr. BLILEY. Do you plan to do any further studies on it?

Dr. BALDWIN. We have one study under consideration now and our concern is whether we will get enough cases in the study to enable it to answer any questions about adoption.

Mr. BLILEY. Is early prenatal care associated in any way with a supportive family? Do you have any statistics as to whether supportive families, you know, where the young mother elects to live with the parents in a supportive family, whether they receive more prenatal care or earlier prenatal care than others?

Dr. BALDWIN. While I do not have statistics that directly relate to this question, it has long been observed that unmarried women are less diligent about receiving early and fully adequate prenatal care than are married women. Also, younger teens do less well than do older teens. They are more likely to receive no prenatal care or begin care late in pregnancy. The younger teens are more likely to be residing with their families, but it is not possible to say how many concealed the pregnancies from their parents, how many were treated in a supportive manner, or whether that support was related to the pattern of prenatal care.

Mr. BLILEY. It seems that too often when discussing the rates of adolescent pregnancy, we do not separate the rates of married teens from the rates on unmarried teens. For example, you say that 48 percent of young mothers soon after birth said they wished that their child had been born later or not at all.

Dr. BALDWIN. Yes.

Mr. BLILEY. It seems to me that this is a reasonable place to make a distinction between married and unmarried mothers. Why is the distinction not made?

Dr. BALDWIN. That calculation of the percent who would prefer their first birth to be later was not subdivided by marital status. An analysis of data from the women when their child was between 3.5 and 5 years old showed that the proportion of teen mothers who would have preferred that their first birth had come later had increased to 78 percent. The younger the teen at the time of the first birth, the longer the desired delay. A statistical analysis showed that marital status, whether the birth was planned or unplanned,

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and other social and demographic measures did not influence this conclusion.

What I have presented in my testimony have largely been research conclusions where I can point to a number of studies that come to the same conclusion and where I can point to conclusions that are statistically robust. That sometimes, unfortunately, does not allow you to see all of the details that you would like to.

Mr. BLILEY. Are births to unmarried mothers associated with poor prenatal care across all economic lines and across racial and ethnic lines?

Dr. BALDWIN. Generally, yes.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. LEHMAN. We would like to hear now from Mr. Miller, the chairman of the full committee.

Mr. MILLER. Mr. Leland was here first. He was waiting. I will go after him.

Mr. LEHMAN. Well, are we taking it according to arrival time or according to rank? [Laughter.]

Mr. Chairman, I have only one question, and therefore, I can yield the balance of my time to the chairman of the full committee.

I would like to ask, other than those teenagers under the age of 15 who are at greatest risk for poor social and medical outcomes, are there subgroups of young people who face greater risk with early pregnancy and childbearing?

Dr. BALDWIN. Let me break your question into two. In terms of the outcome of the pregnancy, low birth weights or higher rates of infant mortality, there are very definite black/white differences. We have been concerned about low birth weight among teenage woman, but the birth weights for black women almost at any age are cause for concern. So there are very definitely subgroup differences.

If you look to other outcomes and ask about the effects on the mother, there it reverses. In fact, most of the studies are quite consistent in showing that the effects seem to be less severe for the black adolescent than for the white adolescent. The presumption is that there are more supportive networks in general for black adolescents than for whites.

Mr. LELAND. Wait, that is contrary to what I have heard. Can you elaborate about the more-support network?

Dr. BALDWIN. When you look at what the educational loss is to the young woman who has a child when she is a teenager and you compare it for blacks and whites, the loss is less for the black adolescent than for the white adolescent.

Mr. LELAND. I see.

Dr. BALDWIN. There are a number of possible explanations for that, but one of the explanations is that, in general, the black adolescent will find a more supportive environment. That may simply be due to the fact that early childbearing is more prevalent among most black communities and that, in fact, there is a point where you have to learn to cope with something, regardless of how much you may dislike it. Those coping mechanisms may be better developed.

Mr. LELAND. I have just heard a lot of information contrary to what you are saying. I would like to pursue this if I can at some time.

Dr. BALDWIN. Surely, I would like to see the information you have. It is important to remember that there may be two ways of looking at a problem: One from a clinical perspective of teens who come into one service organization or one area; second, the general research picture. Both of those views tell you something very important about the process but sometimes you cannot generalize from an experience in one city, an experience in one clinic, or an experience in one program.

Mr. LELAND. Sure.

Mr. Chairman, I yield back the balance of my time.

Mr. LEHMAN. All right. The gentleman from Maine.

Mr. MCKERNAN. Thank you, Mr. Chairman.

Dr. Baldwin, I apologize for missing your statement. I did just have two quick questions. I think most of us would agree that we have to be doing everything we can to prevent unintended teenage pregnancies. We might disagree among us on how much of that ought to be done in a supplementary nature outside the home, but I wonder if you could just indicate to us what the research shows on the effectiveness of sex education in reducing teenage pregnancy.

Dr. BALDWIN. Interestingly enough, we have a study that does address the influence of sex education. Let me explain what the measures are: Whether teens report that they have had a sex education course and then the content of that course. We find that teens who have had sex education are no more likely to be sexually active than teens who have not had sex education.

We also find that the teens who say they have had sex education are less likely to have become pregnant than the teens who said they did not have sex education.

Mr. MCKERNAN. Let me just interrupt you. By more or less likely, that could be, I guess, differing degrees. Do you have any percentage figures on that? Are we talking about a significant difference, or significantly more likely, or less likely, or just a little bit?

Dr. BALDWIN. I am not reporting anything that I would not be willing to say is statistically significant. I do not have all of the information with me——

Mr. MCKERNAN. Could you furnish those for the committee?

Dr. BALDWIN. Certainly, I would be happy to.

[The information follows:]

Question from Mr. McKernan:

You have reported that teens who have had sex education are not more likely to be sexually active, but are more likely to use contraceptives. Can you provide data on that?

Response from Dr. Baldwin:

An analysis by Dr. Melvin Zelnik and Dr. Young Kim found the following:

Table 3. Percentage† of never-married young people who have had sexual intercourse, by whether they had had sex education, according to race and age, 1976 and 1979

Sex education status	Women								Men			
	1976				1979				1979			
	White		Black		White		Black		White		Black	
	15–17	18–19	15–17	18–19	15–17	18–19	15–17	18–19	17–18	19–21	17–18	19–21
Had sex education	28.5	80.0	57.6	78.8	33.6	84.7*	58.4	82.8	84.7	79.4	75.0	92.6
(N)	(356)	(188)	(294)	(156)	(458)	(265)	(275)	(175)	(196)	(204)	(120)	(99)
Did not have sex education	20.6	45.6	46.2	81.2	31.9	71.2*	58.4	87.5	50.6	69.6	81.2	90.2
(N)	(180)	(57)	(66)	(48)	(139)	(69)	(121)	(72)	(59)	(56)	(64)	(51)

*p ≤ 0.05 †Percentages are computed from unweighted data.

Source: M. Zelnik and Y. J. Kim, "Sex Education and Its Association with Teenage Sexual Activity, Pregnancy and Contraceptive Use," Family Planning Perspectives, Vol. 14, No. 3, May/June 1982.

There are twelve comparisons of the sexual activity of those with and without sex education. In seven of them, those who had had sex education had higher proportions who initiated sexual intercourse and in five of them the reverse was true. This gives a clear impression that there is no relationship between having had sex education and being a non-virgin. Subsequent statistical tests reveal that one of the comparisons is statistically significant: in 1979 the white 19 year olds who had not had instruction were more likely to have had sexual intercourse than those who had, 71 percent as compared with 55 percent.

These data do not include information on when the teenager had the sex education. This, of course, is not a problem for those who report that they have had neither sex nor sex education. For those who have had both sex and sex education, some had the sex education prior to becoming sexually active and some had it after becoming sexually active. Among those who report both sex and sex education, some were sexually active prior to having had any sex education, and, for these teens, the sex education could not have affected the sexual activity. Given the overall finding that there is no effect of sex education on sexual behavior, this possible misclassification is not a problem. For example: let's assume that 50 percent of those with sex education are sexually active and 50 percent of those without sex education are sexually active. If among those who had sex education, all had sex education prior to becoming sexually active, there is no "increased risk" of sexual activity since the same percentage were sexually active who did not have sex education. If all had sex education after they became sexually active there can be no effect of sex education on the initiation of sexual behavior; again, that is the conclusion.

In regard to contraceptive use, the use of prescription methods appears to be independent of sex education. When we look at the patterns of use of any method, those who had sex education were more likely to have been protected at first intercourse. This finding, while not statistically significant for data collected in 1976, was statistically significant for tests of data in 1979.

Among those teens who report receiving education which included information on modern methods of contraception, such as the pill, pregnancy rates were lower in all comparison groups, but the difference was statistically significant only for young black women surveyed in 1979.

Dr. BALDWIN. That study does not have an exact dating of when they had sex education and when these other behaviors took place; when they became sexually active. Without going into the technical aspects, that does not hurt the conclusion. If anything, it makes the conclusion stronger when you deal with these technical problems.

Those who have had sex education are not more likely to become sexually active. Those who have had sex education are, however, less likely to experience a pregnancy.

Mr. MCKERNAN. What does the research show on the effectiveness of family planning services?

Dr. BALDWIN. In terms of looking at pregnancy rates by the use of a medically approved method, which, in general is a medical method—generally, the research shows that the girls who are using medical methods have very low pregnancy rates. Women using other methods have higher pregnancy rates; women using no methods have much higher pregnancy rates.

Mr. MCKERNAN. Could you furnish those figures as well to the committee?

Dr. BALDWIN. Surely.

[The information follows:]

Drs. Zelnik and Kantner, of Johns Hopkins University, conducted a national survey of adolescent women in 1976 with funding from NICHD. (Surveys were also conducted in 1971 and 1979). The 1976 data were used to estimate the probable number of additional pregnancies that would have occurred if no unmarried sexually active teenagers had used contraception. They conclude that in addition to the 780,000 pregnancies to unmarried women recorded in that year there would have been 680,000 additional pregnancies, for a total of 1,460,000 pregnancies to unmarried women aged 15–19. On the other hand, if all the teenagers who did not intend to give birth had been consistent users of contraception there would have been about 467,000 premarital pregnancies (half of them intended) or 40 percent fewer than actually occurred. The difference between no use of contraceptives and consistent use by those who do not want to conceive is one million pregnancies. A separate analysis of the effect of family planning programs on teenage fertility results in the estimate that enrollment in the family planning program averted 119,000 births in 1976. Since 36 percent of unintended pregnancies end in live births, family planning programs resulted in the prevention of an estimated 331,000 unintended pregnancies. By putting these two analyses together it appears that family planning programs were responsible for half of the averted unintended pregnancies in 1976. This estimate is consistent with the observation that about half of teens who are contraceptive users report they are served by clinics.

Mr. MCKERNAN. Thank you.

I yield back the balance of my time, Mr. Chairman. Thank you.

Mr. LEHMAN. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. Leland asked you about differences that migh exist in the level of risk for pregnant teenagers from different subgroups. What do we know about the differences in outcome with respect to family economic background?

You mentioned at one point in the beginning of your testimony that not all teenage pregnancies end up in broken marriages, disadvantaged children and loss of educational opportunity. Some have better outcomes. Is this close to the economic resources that are available to the young woman and her husband or boyfriend?

Are economic factors more telling than racial?

Dr. BALDWIN. Basically what we show is that the teens who have access to some resources, perhaps a grandmother to help care for

the child, stay in the home and are able to finish school. There are resources that can be made available from within or presumably from outside the family that will help to mediate the effects of that early birth.

Mr. MILLER. It appears from your testimony that if you are a low-income young teenager without some extenuating circumstances in terms of resources, this may be the most traumatic event of your life. Again, your testimony strongly suggests that it is not just around the nine months of the pregnancy or the first year of birth, but this event continues to play itself out, may even repeat itself time and again.

Dr. BALDWIN. You are absolutely right.

Mr. MILLER. There are—I am just trying to get clear in my mind what you have said. In some instances, there may be extenuating circumstances. There may be an extended family that can absorb the child and the mother; there may be the responsible father who joins up in partnership, whether marriage or otherwise; there be economic resources in the case of a middle-income or upper-income child, but absent that, we are talking about a real detrimental event here.

Dr. BALDWIN. Absolutely.

Mr. MILLER. For child, mother, father, family and everyone included.

Dr. BALDWIN. And this is not just around the time of the birth. We see it in studies that look at these women and the children 5 years later, 7 years later, 10 years later. When you look at them, say, 10 years later, you find that the adolescent childbearers are working more hours, are more likely to be in the labor force but they are making less money; they are in less prestigious jobs. They have less job satisfaction.

Mr. MILLER. If you subtract the incident of pregnancy from adolescent sexual activity, do we know if it alone is harmful?

Dr. BALDWIN. There is much less known about the effects of sexual activity in the absence of a pregnancy or birth. Early initiators seem to exhibit more unconventional behavior in other areas, such as smoking and alcohol or drug use. These activities are viewed as more of a constellation of behaviors and it is not clear which, if any, is casually related to the others. One study shows that early sexual activity is related to early marriage and, of course, there is the risk of contracting sexually transmitted diseases.

Mr. MILLER. Do we have studies on teenagers who become sexually active at 14, at 16, at 18, regarding its effects on them? Do we know whether or not it is a healthy or nonhealthy experience?

Dr. BALDWIN. I don't know of any research that addresses whether it helps them in an interpersonal way.

Mr. MILLER. I asked this question because sometimes the statistics for out of wedlock births so shock us that we forget to be precise in our analysis. Can we, from the data, tell whether it is a sexual activity that is detrimental, or whether it is the incident of pregnancy that is detrimental? I wonder how we best concentrate our programmatic efforts? Everyone in this room would have to think back to that time in their life when they became sexually

active to determine whether it was positive or negative, or what the impacts were. I assume that is true for every individual.

But in terms of public policy, whether it is in terms of the economic resources these teenagers and their babies require, or health resources for the baby, or educational resources for the mother, to help in these areas; it seems to me that we should probably concentrate resources around the pregnancy, whether it is prevention or care.

It seems to me that that is the pregnancy which gives rise to the other impacts.

Dr. BALDWIN. The problem is the risk of pregnancy is really very high, given that a teen is sexually active. For girls who begin sexual activity before age 15, 37 percent become pregnant in the next 24 months.

Mr. MILLER. I grant that. We can make it a felony to become sexually active, but I am not sure that that would have the same impact as counseling or education or awareness or family concern.

Dr. BALDWIN. When you are talking about primary prevention, you can focus on preventing the first pregnancy; you can focus on preventing sexual activity. Sexual activity is very difficult to deal with because it is age-graded behavior. It is not like robbing a bank. It does not matter who you are or how old you are, if you rob a bank, it is a bad thing to do. When you are talking about sexual activity, it is something that virtually everyone is going to engage in at some point.

The question is, how bad is it when you are 15 relative to when you are 17; how bad is it at 16 relative to 19——

Mr. MILLER. But an alarm does not go off when that decision is made, you know, in terms of a warning. People don't naturally stop at that point and consider the resources that are available to them.

Dr. BALDWIN. Oh, absolutely.

Mr. MILLER. No one's skin turns blue, no one says, "Oh, oh, we got one here."

[Laughter.]

Mr. MILLER. This testimony does, again, raise the importance of adequate resources in terms of preventon and education about what pregnancy means. We are really talking about an event that plays itself out at least over the next decade of these individuals' lives, if not much longer.

Thank you, Mr. Chairman.

Mr. LEHMAN. Mrs. Schroeder, the gentlelady from Colorado.

Mrs. SCHROEDER. Thank you very much.

I would like to pick up where Congressman Miller left off. I think you are talking about sexual activity being an age-related problem. When you couple it with the impact of television, one of the major factors in our society, on incredibly impressionable young people, I really worry about what transpires. That is why sex education courses have so many things that they want to accomplish. Nevertheless, they may meet only 1 hour per week. Right now, I will bet that half of America's children are watching soap operas, which are dealing with sexual activity in a adult level. Since they started wearing Ralph Lauren's at the age of 8, they think they are adults already.

I think that is a real, real problem that we have to deal with, as parents, as church, as medical people, as Government officials, when you interact with your child—your child at 6, mine at 12—you are overpowered by the incredible impact of TV in our culture. You cannot condemn what it is doing because it is meant for another age level. But the child does not see itself as in another age level.

Dr. BALDWIN. You are right. The kind of messages that are being given to the teenager are very pervasive.

Mrs. SCHROEDER. Sure. Take a look at the blue jeans ads alone, and who buys blue jeans?

Dr. BALDWIN. It is not just television; it is a whole range of forces in society. I do think that the research gives us a few clues about this. We know that teens have difficulty managing contraception. Let's say they were given all of these messages to be sexually active, I think most would hope that they would protect themselves against an unwanted pregnancy.

We know that some teens have a lot of difficulty doing that, and some research shows that this is a problem for teens who have not had a role model that shows them how to manage their personal behavior: How you figure out a personal problem from start to finish and what you will do and how to deal with it. It is a model of efficacious behavior that is not strictly tied to income level or anything else. We know that people can, in effect, teach that behavior, and if it has not been taught just routinely in the home, maybe we can teach that in a specialized way.

We also know that the age that the parents became sexually active and had their first birth is clearly related to the age at which the child will do so. The problem is that the definition of "early" has changed. Let's say 20 years ago an early initiator was 18. Their child is likely to be an early initiator, but now "early" is not 18; "early" is 16.

That is a difficult message for parents to understand. We know teens have a tremendous mish-mash of information about sexual behavior, sexuality and contraception. I am not saying that education alone is a panacea, but one would hope that teens had basically accurate information and coping skills and some understanding.

Mrs. SCHROEDER. I always worry about the sex education courses because so many of them I have seen have really been a basic plumbing course, the relentless pursuit of the Fallopian tubes. The kids say, "So what." Yet it does not tell them what they need to know, which is how do they deal with their emotions with all the stimuli from outside with the age differences, with their morals, with where they stand with your parents.

So I think, even when you talk about sex education, we have to make sure it is not the plumbing course. We need to start asking the very hard questions, both as parents and everwhere else. You have to be careful, education, alone, will not do it.

I wanted to ask if you had seen studies, about the problems of teenage mothers, especially the young ones, who were not going through the pair-bonding that most mothers go through with their babies. As a result in some urban hospitals there was a surge in the return of babies to the steps of the hospitals, after a certain

period of time. It was kind of like, "I have done it; I am tired, the baby bothers me; it is not like a doll."

Have you seen any studies on that?

Dr. BALDWIN. I do not have any studies, but I know a number of years ago that scenario was being reported in terms of adoption agencies. Adoption agencies were purportedly seeing more adolescent mothers bringing in 2-year-olds and saying, "Now I want to place my baby for adoption." I was never able to find any substantiation of that. I went through child welfare organization and other sources that would have data and they basically said, "I do not know, maybe it happens some place," but in fact, we cannot find any evidence that that is happening generally.

Mrs. SCHROEDER. I think that Mass General Hospital, in Boston reported this. I think some of the women psychiatrists noted a return of babies. I think it might have recurred just a couple of years ago.

Dr. BALDWIN. I would like to hear more about it because that is something that has come up a couple of times and it is a difficult thing to research. The prevalence is likely to be so low that it is hard to measure it.

Mrs. SCHROEDER. Let me quickly ask one more question about the "squeal rule." I think the implication is it is a form of sex education; which may be the magic cure-all to stop teenage sexual activity. And yet there are many doctors who will testify that we are almost in an emergency type of situation because many teenagers who become pregnant are in a high risk category. It could be argued that contraception is an emergency kind of treatment. That it is simply a different time frame in which this emergency occurs.

Have there been any studies about the "squeal rule" that would give discretion or guidance to the medical people to use it depending on the kind of background that might merit it? It does appear to be one way to intervene in a crisis, but in this kind of crisis, are you wasting your time and only exacerbating the crisis?

I think everybody comes with their own views from their own family. I think that is what Congressman Lehman was getting to. Do we want to know, as parents? Well, our situation might be a little bit different than another one where it is not even really clear who the guardian parent is and so forth.

Dr. BALDWIN. There are provisions in the rule to allow some discretion in terms of whether the parents are notified. They are pretty tightly drawn. If there is a reason to believe that there would be physical abuse, for example, then the parent does not need to be notified.

I do not know of any really wide-ranging analyses of an aftereffect of having imposed a parental notification rule or parental consent rule. We know something from research that looks at kids who come to the clinic and asks why they did not come sooner. This is an important question because many have been sexually active for a year, maybe more, before they come. One of the reasons that is given is the fear that the parents would find out.

There is plenty that the parents should be doing and they could be a tremendously valuable and useful force when we look at the problems of adolescent behavior. They are ideal for helping the adolescent before the adolescent says "I need help." The clinics are

fine; they deal very well with an adolescent who comes in and says, "I need help"; "I am sexually active"; "I want contraception." But we have vast problems that occur before that, and they need to be addressed by parents, by schools, by youth groups, by churches, by those who have day-to-day contact with the adolescents and can monitor and see their behavior.

Parents know what the dating behavior is; parents know whether the child is physically mature. We know that, generally, children are not sexually active until after they are physically mature. Parents have a lot of clues that sexual activities could be an impending problem and have daily unstructured contact with that child. I would like to see us working to develop ways to help the parents make the most of that time.

Mr. MILLER [presiding]. The gentlewoman's time has expired.

Mr. WOLF. Thank you. I will not take a lot of time since I am not on this task force, but Mrs. Schroder's question raised a point. I agree with just about everything she said. What can we do with regard to educating adolescents to abstain in light of Mr. Miller's reasons of the hardships they may face for the next 10 years, lack of education, and lack of earning? What can be done knowing that everyone does not live in a two-family household and with parents. Not everyone belongs to certain associations.

Do you have any idea what we can do to encourage young people to understand the consequences of their actions, not just for the dangers and the plumbing reasons, but also for the reasons that Mr. Miller was talking about, the hardships that they have for many, many years thereafter? Is there anything that you can recommend?

Dr. BALDWIN. There seem to be indications that teens respond to service programs that do deal with the needs that they have, which are not exclusively the plumbing needs, but the need to help them think through how they are going to handle boy/girl relationships. Teens do seem to want that.

I believe we have to think very creatively about the kinds of programs that we can make available to them—the programs that we can make available early. You really have to pick up the teens when they are interested enough that they will pay attention.

Mr. WOLF. What age is that?

Dr. BALDWIN. That is going to vary. It is going to be different for blacks and whites as I look at the data. As I look at the data on sexual activity, there is much more sexual activity among young blacks than among young whites. Also, you are going to have a problem if you have a class of 12 year olds, they may be at totally different stages in development. The schools may be handicapped. You may be better off focusing on youth groups, churches, social groups, places that have not just family planning services, but have a whole range of services for teens. One way that you can help is to involve the teens at the time they are becoming ready for heterosexual relationships.

We know that teens are generally not sexually active until they are physically mature. So for girls, we have a clear signal in menarche, and, in fact, most are not usually sexually active right then, but may be within the next year or two.

We have a very clear signal, certainly for the girls, regarding when they might be in need of information and services. I have a "pet project" in that I think this would be wonderful to do through computers, because you could have teens able to access a system that would help them think through problems, and which could provide information that was individualized for their particular age or needs. But that is my own pet project.

Mr. WOLF. Thank you very much.

Mr. MILLER. Mr. Weiss.

Mr. WEISS. Thank you, Mr. Chairman.

Dr. Baldwin, I have two questions which you may have fully responded to already, but perhaps there is an area for you to clarify, to expand on. One is the, I guess, takeoff on the very last question that you addressed.

Can you expand at all on your remark about what teenagers report on the basis of your study that they want to know or learn in terms of sex education?

Dr. BALDWIN. Sex education is not really a part of the program with which I am associated, so I will not be able to give you as complete an answer as I would like. But the programs that deal with teenagers do seem to show that they want more than just the plumbing and more than just "Here is the pill and here is how you take the pill"; "here is a diaphragm," teens are concerned with being able to deal with sometimes difficult relationships they are experiencing.

It is very difficult, if you think back to adolescence, learning to engage in boy/girl relationships and to make decisions about your career; make decisions about education. Teens are at an often difficult and relatively turbulent time of life. A lot of teens do seem to be interested in someone who can help them see ways to negotiate that.

A project carried out in Seattle used instruction and role playing to develop communication skills related to contraception and other sexual behavior. Teens were able to rehearse in the group setting with an instructor the kinds of situations they might face, situations like how to tell your boyfriend or girlfriend that you do not want to have sex anymore unless they use contraception. The program helped them think through different solutions to their problems in a very concrete manner. They not only dealt with decisions about behaviors but about the specifics of implementing those decisions. For example, it might be easy to decide that one needed contraceptive protection, but more difficult to figure out the steps that needed to be taken: What exactly would one say to the druggist when buying condoms?

In some families, this learning about decisionmaking and implementation happens naturally. They have seen the parents deal with problems; they have seen the parents work through it; they know how the parent goes into a store and does something that is a little difficult. They see the parents themselves working out difficult situations between the two and they have those roles right there.

Mr. WEISS. Do you have any studies at all indicating any evaluations, I guess, by the kids themselves, of the quality or the caliber of the sex education programs in school, out of school, whatever?

Dr. BALDWIN. A Gallup poll conducted in 1978 reported that four in ten American teens had had a sex education course in school and 3 in 10 had some instruction in birth control in those classes. Of those who had sex education, 82 percent rated them either very helpful or fairly helpful. Only 17 percent said they had been of no help. Those whose classes included discussion of contraception were more likely to report them very helpful and less likely to report them of no help. Interestingly, more young teens (13 to 15) reported the classes very helpful than did older teens. This was especially true for boys, where among boys 16 to 18, almost a third reported them as being no help. One reason given was that the classes were too superficial. A study discussed earlier pointed to the success of clinics in attracting young boys—junior high school age—but failure to attract older teenage boys.

Mr. WEISS. The final area. Again, perhaps you have answered this as fully as you can on the parental consent or notification requirements. There is, as you have indicated, and questions have indicated, a great deal of controversy about what the effects are. Some people believe that a parental consent requirement for family planning will decrease sexual activity among teenagers and result in fewer teenage pregnancies.

Others argue that there will be more teenage pregnancies because young people will shun family planning services. Similarly, it is sometimes argued that the parental consent requirement for prenatal care will lead to better pregnancy outcomes. Others say that it will discourage teenagers from seeking early prenatal care and this will jeopardize pregnancy outcomes.

Does the research show at all what the effects are of parental consent or notification requirements?

Dr. BALDWIN. There are studies that show, as I reported earlier, when you ask kids why they came so late, why they waited a year before they came, it was because in many cases, they were afraid their parents would find out. Then they discover their parents are not going to find out, they get worried about pregnancy and they come to the clinic.

I do not know of any studies that would reflect on parental consent relating to prenatal care. You have to remember; for a lot of these teens, they are trying to hide the behavior. I am very concerned that we find ways to reach the teen and involve the parent of the teen early. But when you talk about trying to do that at the time the teen has already come for services, I think that is late. I think the research would say that if you can find a way to involve the parent earlier, it would probably be quite helpful and there might be parental support; and more parental communication. But the situations you have outlined for me are cases where the teen has already come to a service. I do not know of any research that would enlighten that any more than I have already reported.

Mr. WEISS. Thank you very much.

Mr. MILLER. Mr. McHugh.

Mr. MCHUGH. Thank you, Mr. Chairman.

Dr. Baldwin, first of all, my apologies for having missed your opening statement. What I have heard since then is very interesting.

I gather that a key point is that sex education at an early age is most important. Moreover, this education should not be be formalistic only. It should also try to involve the parents and teenagers or youngsters in social groups with which they are comfortable.

Conceding the importance of this, my question is, do you have any recommendation as to where the Federal Government can play a role, which it is not now playing, which could be helpful in this area?

Dr. BALDWIN. Bearing in mind that sex education is not a primary part of my program, I see a need for research on how you can involve the parents; research on what the parents need to know; research on who the best person is to provide that information. It is not necessarily the parent of the particular teen. For some teens, that may be an impossible combination.

I do think we need to think more creatively about how we can reach kids and at what ages. I do not want to minimize the difficulty of this, because the most serious problem, in terms of the outcomes, or the likelihood that a girl will be sexually active and not come for services, is for the youngest teens. But when you are talking about 14-year-olds, there are still relatively few 14-year-olds who need these services. So if you have got an elementary school there may be hundreds and hundreds of students but only a handful who really need services. That is a tremendous burden to put on a school. That is why we have to think about a lot of different ways that you can reach kids, especially when you have to reach the very young ones. They are going to be the hardest to reach.

Mr. MCHUGH. This is a difficult question. It seems to me that we are not doing very well in this respect at the moment. That is, under the cirsumstances, the schools are doing the best they can but with regard to these other mechanisms, we really have only scratched the surface.

Dr. BALDWIN. Oh, yes. You mean family and church?

Mr. MCHUGH. Yes.

One last question. You may have covered it in your opening statement. With respect to the incidence of teen pregnancies, is there a direct relationship between that and income group?

Dr. BALDWIN. Most studies will show higher sexual activity and higher risk of pregnancy among lower SES groups, but adolescent fertility is not a problem that is isolated in any group. It does not matter so much that the rates may be a little higher in one group or lower in another group; there is no group where we can say, "This is not a problem."

Mr. MCHUGH. The obvious reason for asking that question is that with many programs, we target our research and our resources. However, what you are saying is that there is not a significant enough difference between income groups to warrant targeting the research or the resources? Is that right?

Dr. BALDWIN. There are groups where the risk is greater. So if you cannot do everything, you certainly have a clear indication of where the greater risk is. But on the other hand, if that leads you to think that the higher-income groups have no problem; that certain racial or ethnic groups have no problem; then that is a mistake. It is a little bit of both.

Mr. MCHUGH. Thank you very much.

Mr. MILLER. Mr. Marriott, do you have any questions?

Mr. MARRIOTT. Thank you, Mr. Chairman.

I, too, apologize for missing your earlier statements, but when you are trying to run between seven committees, you have a problem.

Let me just ask you one question along this line of sex education. Again, I missed your opening statement, maybe you covered this, but for some reason, among a lot of our religious and family-oriented types of groups, sex education has a bad omen attached to it. Some people believe that if you concentrate on that area, that you will indeed encourage more teenage sexual activities than even now occurs.

The question, then, comes about what the alternative might be. What do you think about the possibilities of, rather than concentrating on sex education per se, concentrating more on required classes in school around the idea of parenting, responsibility, and educating the kids in terms of what happens when a teenager gets pregnant, the problems associated with out-of-wedlock births, for example, the health problems of the babies, and the history of what has happened to some of these kids that get themselves into some difficulty.

Could you not address the issue more along that line than just fueling the fire of "sex education classes"?

Dr. BALDWIN. I would like to respond in several ways. One is that the research evidence that we have shows that the teens who have had sex education are no more likely to be sexually active than the teens who have not. I am not at all sure that providing sex education, we are "fueling the fires" in terms of them being sexually active. I do not find that very surprising because if you think about an hour of class in sex education, which may be heavily loaded on discussion of Fallopian tubes, and then you think about all the interpersonal things that go into making a decision to be sexually active or not, it may be stretching one's imagination to think that that hour of talking about Fallopian tubes is really likely to change a whole course of interpersonal behaviors that lead to sexual activity.

However, it is clear that what comes in under the rubric of sex education can either be very narrow or it can be very broad. It can help teens to understand how they can control their lives and make decisions that they want to make and follow through with them or it can superficially deal with biological matters. I think that is very helpful in the area of sexual behavior and just boy/girl relationships. You can provide some skill training there that would be very useful to them.

I would love to see more done to inform adolescents about the risks of early childbearing and the kinds of costs and benefits that accrue to them.

Mr. MARRIOTT. Do you think the schools in general do anywhere near enough in this area?

Dr. BALDWIN. Sex education is not my specialty, so I really cannot say, although it appears that a substantial minority receive no sex education in schools.

Mr. MARRIOTT. In my part of the country, the arguments are on whether or not planned parenthood is a good or a bad deal. The

arguments are struggling against that. I do not see much going on in the schools in terms of what we just talked about, in terms of trying to broaden the educational—and giving these kids some idea of what goes on in the real world. Do you think there ought to be more done in this regard?

Dr. BALDWIN. Well, I have outlined a whole range of trends and problems and behaviors. I do not think the schools can do it all; I do not think planned parenthood can do it all; I do not think the family can do it all. But we have a very complex problem and we have pieces of it that can be done very well by family planning services; we have pieces of it that can be done by the schools, maybe better; we have pieces of it that can be done by the family; pieces that probably can and should be done by other community organizations.

Perhaps, if we are concerned about the kind of generalized messages that are received through television, we need to think about other messages that can be received there. But I believe that it is a mistake for us to focus in on one piece of this very complex puzzle, whether it is family planning or families or sex education or schools, TV or rock music, and say, "That is the problem and we are going to go in and change it." It is much too complex for that.

Interestingly, now that I have a 6-year-old, I was watching cartoons Saturday morning and there was a cartoon talking about the problems this boy and girl were going to have if they had a baby. They were too young to have a baby and they did not want this-and-such to happen. It was terrific. That is the kind of things kids are watching. I do not know whether that has any effect, but it certainly was an attempt to kind of balance some of the messages.

Mr. MARRIOTT. Thank you very much.

Thank you, Mr. Chairman.

Mr. LEHMAN. The gentlelady from Maryland.

Ms. MIKULSKI. Thank you, Mr. Chairman.

Dr. Baldwin, in your research, and in answering the questions, I wonder if you could give us a profile of the woman who is most likely to get pregnant, and also, the male who is most likely to get someone pregnant.

I would like to focus, also, my questions on the boys because it seems in this conversation we have been speaking only about the females as if this occurred in a vacuum.

Dr. BALDWIN. OK. That is a very difficult question.

Ms. MIKULSKI. That is why I asked it. [Laughter.]

Dr. BALDWIN. In terms of a profile, we certainly can piece together information from a number of different sources and say, "Well, we have some indicators." I guess if I were in a family and I said, "All of these things look like they apply to my child," I would be very worried about that child.

We know that, in general, teens are not sexually active until they are physically mature; the physical maturity precedes the social involvement. So, I think as a parent, I can say there are going to be pretty good markers here as to when sexual activity is likely to commence.

We know that if the parent is an early initiator—had sex early or had a first birth early—it is likely that that is going to be a good predictor of the child's behavior. The problem with that is it may

have been at the parents' generation—18 might have been early—and for the child's generation, 15 or 16 may be early. So, the parent may be thinking, "Well, this did not happen to me until I was 18; that is when I am going to worry about my child." I would suggest that they start worrying about 3 years earlier.

There are studies that show that many of the girls who have lower educational aspirations or less involvement in school are at greater risk. One fascinating longitudinal study done in Scotland showed that the girls who did become pregnant as young teens had—before that pregnancy—a falling-off of their achievement relative to their aptitude. They were doing less well than they could do; not just doing poorly, but less well than they could do.

Very shortly, we will have U.S. data to test that, and I think that is going to be a very exciting project because that could be a very good marker.

We know that the teens who are more religious, more involved in family activities, more integrated into their family, where the families are doing things, where the family has strong religious beliefs, are less likely to become involved in early sexual behavior. I do not know how you foster that. I will say that looks predictive so that you can say, "Well, if you are a loosely formed family and you do not have any particular religious involvement, then maybe that means your child is at greater risk." But from a programmatic standpoint, I think that is an interesting observation, but I do not know that it has any programmatic implications.

Ms. MIKULSKI. And for the male?

Dr. BALDWIN. We have a very strong interest in the male. We have tried a number of times to foster research on the male. We have not been totally successful. We know that the males are, age-for-age, more likely to be sexually active. We know their levels of knowledge about contraception are, if anything, worse than the girls. We get only vague and systematic reports of their motivations regarding the prevention of pregnancy or feelings after the pregnancy.

That area is very, very hard to pull together. Males are hard to interview; it is hard to keep male interviewers; and the quality of interviews with males is not generally as high as for females. We are really years behind in terms of knowing how to craft and carry out the types of research projects that we need to do on the male.

Ms. MIKULSKI. Isn't that intrinsic to any public policy that we do, rather than focusing strictly on the female?

Dr. BALDWIN. Well, it is possible. We have looked at this issue in our fertility research. In general, we have tried to not just use data from women. From wives' reports, we have their husbands' attitudes, their husbands' education, but perhaps we should get the data directly from husbands. This raises an empirical question: Are we really better off if we have information directly from the man, or if we have only the woman's report? Maybe the woman's report is really the more important.

Ms. MIKULSKI. In the time that we have, I would like to just ask two quick questions. If a 14-year-old girl gets pregnant, how old is the father likely to be? If a 12-year old gets pregnant, how old likely is the father to be?

Dr. BALDWIN. We don't have data that give us the ages of the fathers for all teenage births but most of the teenage girls are involved with teenage boys who are a few years older than themselves.

Ms. MIKULSKI. What I am trying to get at, if a 12-year old gets pregnant, is she getting pregnant by 19-year old or a 14-year old, a 13-year old?

Dr. BALDWIN. It is probably a 14- or 15-year old.

Ms. MIKULSKI. A 14-year-old boy. So, that if a 12-year old is engaging in sexual activity, it is likely then with somebody under the age of 16. Do we or don't we know that?

Dr. BALDWIN. We know in general that there is a 2- or 3-year gap between the age of the young woman and her partner.

Ms. MIKULSKI. I not trying to quiz you.

Dr. BALDWIN. I am not trying to evade you.

Ms. MIKULSKI. I am trying to get a picture of this, because it goes to the kinds of questions that Congressman Marriott is asking about in terms of educational activities, other kinds of programs.

You know, we have been talking about sex education and girls knowing about plumbing and the pill. Again, that goes to the other sex, as well.

So, for a 14-year old, she is more likely to be pregnant by——

Dr. BALDWIN. A young teenager.

Ms. MIKULSKI [continuing]. Another young teenager. So whatever we focus on, we are not talking about teenager/adult relationships. We are talking about teen-to-teen, and teenybopper-to-teenybopper; is that correct?

Dr. BALDWIN. Exactly.

Ms. MIKULSKI. Then following up on public policy issues, we have talked a lot in our conversation this morning about sex education. One of the items that Congressman Marriott raised which I am very supportive of is do we need a broader educational program, which takes me to another point about data.

Is a person's perception of both the opportunities for a future and the realities of having some type of upwardly mobile future or stable future correlated to the likelihood of engaging in teenage sex?

Dr. BALDWIN. There are a number of studies that conclude that if the adolescent girl feels she is not going to be a high achiever anyway, that there are no jobs for her, and no opportunities that, therefore, a birth at 16 may not be such a traumatic disruption of her life.

There is certainly research to indicate that teens with a sense of opportunity may seek to avoid a pregnancy. Such teens may want to go to college, and having a baby would interfere with that. Most teens have a lot of reasons to avoid pregnancy. There are a lot of things in their lives which make an early birth, an early pregnancy a real cost.

On the other hand, there are teens for whom, when they look ahead as to what is in their life, there are not so many things that make that early birth very costly. Most women are going to have children at some point. So it becomes a question of how disruptive would it be if a child were born while the woman is quite young.

Ms. MIKULSKI. If, No. 1, you don't have high hopes for yourself, and therefore, feel that, one, the world doesn't respect you, so therefore, why should you respect yourself in terms of a future, the more likely you are not to see this as a deterrent to the future; is that correct?

Dr. BALDWIN. I would say so, yes.

Ms. MIKULSKI. So then picking up, again, on how we deal with this, that if we really provided authentic educational and employment opportunities and conveyed this particularly to what we would call "at risk populations," that in and of itself would be a very effective mechanism other than plumbing and the pill.

Dr. BALDWIN. I would say that would be a valuable contribution to a complex problem.

Ms. MIKULSKI. It could also have a tremendous impact, not only on females, but on males, young men in terms of what this means for them.

Dr. BALDWIN. It could. But, again, the data on males are so shaky, it is hard to conclude.

Ms. MIKULSKI. So that the concept of a real education for kids, and particularly poor kids, rather than only having computers to work out "how do you say no," but to have computers to learn how to get a job and maybe not even dreaming of being Sally Ride, but dreaming about maybe working at NASA would be a very important thing that we should look at in that prevention strategy.

Dr. BALDWIN. I think that that could make a valuable contribution.

Ms. MIKULSKI. Thank you, Doctor. You have answered my questions.

Mr. WOLF. Mr. Chairman.

Mr. LEHMAN. Mr. Wolf.

Mr. WOLF. Ms. Mikulski's question brought up a question I would like to ask. She was talking about having opportunities.

Would you just make a quick comment on what is the impact of either self-esteem or lack of self-esteem on adolescence with regard to this.

Dr. BALDWIN. There are a number of studies that would allow me to make a generalized conclusion that lack of self-esteem is one of those characteristics that goes with the poor planning and the poor ability to control behavior that is a part of this puzzle.

I really did not come prepared to talk about our whole range of programs on the research on the antecedents or the causes of early sexual behavior, so I really do not have that literature at my fingertips. But in general I would say that higher self-esteem is certainly a valuable attribute in negotiating these difficult times of adolescent behavior.

Mr. WOLF. Thank you.

Mr. LEHMAN. I want to thank Dr. Baldwin for being here. If other members have questions, they may submit them for the record. We will take the next panel at this time. I hope you will be able to stay with us for awhile.

Dr. BALDWIN. I will stay for the whole hearing. Thank you.

Mr. LEHMAN. Generally, the plan would be to complete panel No. 1, hopefully, within about an hour, and then adjourn for lunch and then come back after about an hour and finish panel No. 2.

Thank you, again, Dr. Baldwin. At this time we have Ms. Elizabeth McGee, Dr. Edward Wynne, and Dr. Effie Ellis. I didn't know which way you wanted to go, but I thought maybe the panel would set its own ground rules.

So you are on your own. If you want to summarize your statements, the statements in full will be placed in the record without objection.

STATEMENT OF ELIZABETH A. McGEE, DIRECTOR, ECONOMIC SELF-SUFFICIENCY FOR TEENAGE PARENTS PROJECT, NATIONAL CHILD LABOR COMMITTEE

Ms. McGEE. I think we will follow the agenda in terms of who is going to speak.

I am Betsy McGee, Elizabeth McGee. Mr. Chairman, and members of the task force, I am very glad to have this opportunity to talk to you about adolescent pregnancy in America.

I have prepared testimony that is sitting in front of you. I want to skip and not read it entirely because many of the things that I have said have been repeated by Dr. Baldwin and by yourselves in discussion with her.

But there are a few points that I do want to emphasize. First, that adolescent pregnancy in America today is a problem of everyone's daughter.

Those of us who have worked in the field (and I have personally worked in the field of reproductive health care for 15 years) know that we see your daughters, my daughters, girls like my daughters—I have two—girls like the daughters of your constituents for all the sorts of services we are providing for young women who have initiated sexual intercourse or contemplating doing so or just concerned about the issues involved in doing so.

The testimony that I have written here, I tried to write in a language that would be very easy for you to pass on to colleagues and to your constituents.

It is my hope that you will do that because we do need to know more in America about what this problem is and to see it as everyone's problems and not just the problem of certain groups.

We are particularly concerned, those of us who work in the field, about girls who are poor and younger than 18 because they are more likely to have problems if they become young parents. Young women from lower socio-economic backgrounds are a special concern because a higher proportion of them bear children as teenagers and premature parenthood makes it far more likely that they will remain poor all of their lives.

Many experts—I think we have covered this point this morning, but I want to emphasize it again—many experts believe that disadvantaged youngsters drift into parenthood because there are fewer options available to them through which they can find a sense of identity, self-worth and a satisfying role for the future.

We must help disadvantaged youth choose less self-defeating patterns by making the alternatives, not only more attractive, but more attainable. That, I think, leads us into thinking about approaches to prevent pregnancy that go far beyond family planning.

Young women who become parents are only half the problem. We are also concerned about young women who choose abortion.

Almost 40 percent of the Nation's pregnant teenagers end their pregnancy by abortion. Very few of these women experience any long-term difficulty because of this choice.

In general, those who do had pre-existing emotional problems more severe than those usually experienced by adolescents.

Nonetheless, abortion can be a painful, expensive, and sad way to end a pregnancy. Because most of us wish teenagers would not have to choose either abortion or parenthood, we are concerned about helping young people avoid pregnancy in the first place.

Unfortunately, there is a great deal of disagreement, at times, even bitter hostility about how to do this. In part, this disagreement reflects very different conceptions about why young people get pregnant and why the rate of adolescent pregnancy continues to increase.

You will, I am sure, solicit many perspectives on this question in your hearing. My own opinion, which I think I share with many others, is that American families and institutions have failed to help young people make responsible sexual decisions because of a profound cultural confusion about what is responsible or moral sexual behavior.

Too many of us convey this confusion or a rigid, absolute standard of morality to young people. Mostly, we are silent or preachy. As a result, our children are the victims of our confusion.

Youngsters turn away from us to work out their sexual values. Of course, to some extent this is natural.

Adolescence is a time of separating from parents and other authority figures. We learned about sex from our peers and through trial and error.

However, all teenagers, like ourselves when we were young, need adults to talk to, to learn from and to emulate.

We have expected much and given very little to our young people struggling toward sexual maturity. We have neglected young men and punished young women.

This is neither fair nor wise, and among other things, it leads to the problems we are discussing today.

Concern about these problems in the last three decades has led to some successes in the field. For example, the incidence of birth to teens has declined, as you know. The school dropout rate among pregnant teens has been reduced, and with adequate prenatal care, as you heard from Dr. Baldwin, the health consequences of birth to young women have been improved.

Nonetheless, despite the successes, most adolescent pregnancies are still unintended, a large number of teens use abortion to prevent an unwanted birth, and the problems associated with teen parenthood persist.

Furthermore, the recession, coupled with reductions in social welfare budgets, may cause young parents additional hardships.

The successes we have had are attributable to many and diverse services available to sexually active, pregnant and parenting teens. Some programs are excellent.

They usually serve a small number of teens with intensive and comprehensive care. I have worked with or visited programs in many of the States that you represent.

A sufficient number of innovative models exist that we can adapt or replicate as needed to address some of the problems we are discussing. As it is, however, in general, services are weak and have a limited impact.

They serve only a small percentage of the eligible population. They are disproportionately focused on pregnancy and on crisis intervention.

Their quality is uneven and their effectiveness is mixed. They are not well coordinated with other services, and many aspects of service delivery limit their accessibility and usefulness.

Services also tend to focus on some teen needs while ignoring others. Welfare is a good example. The need for financial resources is met, but the need for a long-range plan to develop economic self-sufficiency is neglected.

Employment preparation is another. Youth employment programs are not structured to be able to give many teen parents the extra attention they need. Typical teen parent programs provide education, health and social services, but do not, in general, provide for employment assistance.

Family planning is a third example. Because of limited financial resources, most family planning programs provide medical services to young people, but are forced to scrimp on critical educational and counseling services.

Furthermore, because of the unpredictability of Government funding, many fine programs start up and then close. This is costly in many ways.

We lose the experience and expertise that service providers have developed in program operation, also creative and effective approaches are forgotten only to be reinvented in another place some years later.

What can we do then to help young people make decisions about their sexuality more wisely and to help families and youth-serving institutions meet the needs of young people more adequately?

I assume, of course, you are going to be looking at this question in some depth. Let me, just in general, outline some areas that I think we need to look at and be concerned about.

First, we need to improve the approaches to help teenagers prevent or delay the first birth. We must provide support for families and other youth-serving institutions to help young people be sexually responsible and to make other roles besides parenthood possible for young people to achieve.

The role of parents, schools, and family planning services are especially critical.

Second, we must strengthen the organization of services to teen parents. I want to make this point particularly strongly. We know how to help teen parents provide for their children and complete growing up.

There are fine models available for service delivery and coordination. We need to make it financially possible for communities to replicate these programs as needed.

Employment assistance particularly is important. I direct a project at the National Child Labor Committee that is focusing on the sorts of employment preparation programs which are feasible and effective for young parents.

Public moneys are needed to provide more of these programs as needed.

Third, we need to expand the recruitment of teenagers in need of services. Many young parents obviously pass through hospitals when they give birth and through the welfare departments when they collect their welfare checks, but frequently they receive no other services.

Fourth, we need to provide for more extensive evaluation of program models so that effective approaches can be refined, publicized and replicated.

Fifth, we need to find more effective ways to challenge or counter the aggressive sexual sell of Madison Avenue. While it is difficult to assess the impact of the media, it is clearly confusing for young people to be told that early or premarital sex is wrong, while ads, movies and music imply that sex appeal is critical to success in life.

Sixth, we need to continue to explore the ways in which we prevent young women from developing their interests and talents.

Seventh, we need to examine our approaches to service deliveries for young fathers so that we can do all that is possible to insure that they will provide for their child or their children appropriately.

Teenage pregnancy is a major public health problem. When we begin treating it as such, I think that we will find ways to meet the needs of adolescents more adequately so that they can prevent pregnancy until they are prepared emotionally and financially to handle the responsibilities of parenthood.

I thank you for your interest, and I will be glad to provide more information or answer questions, as needed.

Mr. LEHMAN. Thank you.

[The prepared statement of Elizabeth McGee follows:]

PREPARED STATEMENT OF ELIZABETH A. MCGEE, OF THE NATIONAL CHILD LABOR COMMITTEE

Mr. Chairman and members of the task force: I am glad for this opportunity to talk with you about adolescent pregnancy in America. As you know, for the past three decades adolescent sexuality, pregnancy, and parenthood have attracted increasing national attention. The frequency with which pregnancy occurs among young women makes teenage pregnancy a serious social problem: 4 out of every 10 young women become pregnant during their teenage years. They are everyone's daughters.

Each year over a million teenagers become pregnant, and about half of these young women continue their pregnancies to term. Most teenage mothers become pregnant outside marriage. Nearly all of them keep their babies. Forty percent of these young mothers are 17 or younger. A higher proportion of teens in the United States become mothers than in any other developed country except in Eastern Europe.

The problems associated with teenage parenthood have been amply documented as concern about these patterns has led to substantial new research into the antecedents and effects of teenage childbearing. The long-term consequences of teenage parenthood are not fully understood, and there is considerable controversy about how adolescent, unplanned pregnancy affects the lives of young parents and their children.

Some experts consider teenage parenthood an additional strain on young people who are already vulnerable because of pre-existing socioeconomic, family, and psychological problems. They argue that young women who become mothers are "different to begin with" and that this initial difference, coupled with the demands of parenthood, leads to the problems found to be associated with early childbearing. Others argue that whatever the background of the young mother, the social and economic limitations imposed by parenthood at a young age are in themselves a sufficient handicap to create a distinct set of problems.

It seems likely that both points of view are accurate. Many young parents, because of certain background characteristics, are predisposed to have greater difficulty becoming personally mature and economically self-sufficient, and early parenthood does lead to a constriction of opportunities that presents new and difficult problems for the young mother. As a result, many young parents have trouble acquiring the education, training, and experiences they need to perform adult roles. Also, a number of young mothers are frustrated, even overwhelmed, by the experience of parenthood.

The general consensus among specialists in this field then, is that early childbearing presents many risks for young people, especially for young women. In an industrial society, early parenthood disrupts a young person's life by interfering with normal preparation for adult living. While it is by no means inevitable that this will lead to more lasting problems, it is likely, especially if the teen is poor or younger than eighteen.

Young mothers tend to experience poorer medical outcomes during pregnancy and delivery, larger family size and little family stability, inadequate education and vocational training, unemployment or intermittent employment in occupations with low wages and little mobility, and dependency on government services and support. Over half of the 1981 Aid to Families with Dependent Children (A.F.D.C.) budget went to families in which the mother gave birth in her teens.

The children of teenage parents tend to be less healthy, to be less adequate as parents, to achieve less academically, and to repeat their parents' patterns.

Early marriage confers few advantages to the teen parent. Marriage during the teen years—especially during the school-age years—means a greater likelihood of dropping out of school, of having a large family and an unstable marriage, of welfare dependency, and of being a single head of household for a prolonged period.

In summary, teenage childbearing imposes burdens on the young parents' families of origin and makes healthy family formation and functioning very difficult for the young parents. While some young parents—especially those who derive both material and psychological support from their families—are able to minimize the disruption caused by early childbearing without assistance from public or private agencies, many teen parents need help to be able to cope successfully with the challenges of parenthood. It is these youngsters we seek to serve more effectively.

Young women from lower socioeconomic backgrounds are a special concern to many of us because a higher proportion of them bear children as teenagers and premature parenthood makes it far more likely that they will remain poor all of their lives. Many experts believe that disadvantaged youngsters drift into parenthood because there are fewer options available to them through which they can find a sense of identity, self-worth, and a satisfying role for the future. We must help disadvantaged youth choose less self-defeating patterns by making the alternatives more attractive and attainable.

Young women who become parents are only half the problem; we are also concerned about young women who choose abortion. Almost 40 percent of the Nation's pregnant teenagers end their pregnancies by abortion. Very few of these women experience any long-term difficulties because of this choice: in general, those who do had pre-existing emotional problems more severe than those usually experienced by adolescents. Nonetheless, abortion can be a painful, expensive, and sad way to end a pregnancy.

Because most of us wish teenagers would not have to choose either abortion or parenthood, we are concerned about helping young people avoid pregnancy in the first place. Unfortunately there is a great deal of disagreement—indeed, at times bitter hostility—about how to do this. In part this disagreement reflects very different conceptions of why young people get pregnant and why the rate of adolescent pregnancy continues to increase. You will, I am sure, solicit and hear many perspectives on this question.

My own opinion—which I believe I share with many others—is that American families and institutions have failed to help young people make responsible sexual decisions because of a profound cultural confusion about what is responsible or

moral sexual behavior. Too many of us convey this confusion or a rigid, absolute standard of morality to young people. Mostly we are silent or preachy.

As a result, our children are the victims of our confusion. Youngsters turn away from us to work out their sexual values. Of course, to some extent this is natural. Adolescence is a time of separating from parents and other authority figures. We learned about sex from peers and through trial and error. However, all teenagers need adults to talk with, to learn from, and to emulate. We have expected much and given little to our young people struggling towards sexual maturity. We have neglected young men and punished young women. This is neither fair nor wise. Among other things, it leads to the problems we are exploring today—teen pregnancy, abortion, and parenthood.

Concern about these problems has led policymakers, service providers, professionals, members of the clergy, and others to some successes in the field of adolescent pregnancy and parenthood. For example, the incidence of births to teens has declined, the school dropout rate among pregnant teens has been reduced, and, with adequate prenatal care, the health consequences of births to young women have been improved.

Despite the successes the problems are still acute: most adolescent pregnancies are unintended, large numbers of teens use abortion to prevent an unwanted birth, and the problems associated with teen parenthood persist. Furthermore, the recession, coupled with reductions in social welfare budgets, may cause young parents additional hardships.

The successes we have had are attributable to the many and diverse services available to sexually active, pregnant, and parenting teens. Some programs are excellent. They usually serve a small number of teens with intensive and comprehensive care. I have worked with or visited programs in many of the states you represent. A sufficient number of innovative service models exist that we can adapt or replicate as needed.

As it is, however, in general, services are weak and have a limited impact: they serve only a small percentage of the eligible population; they are disproportionately focused on pregnancy and on crisis intervention; their quality is uneven and their effectiveness mixed; they are not well coordinated with other services; and many aspects of service delivery limit their accessibility and usefulness.

Services also tend to focus on some teen needs while ignoring others. Welfare is a good example: the need for financial resources is met but the need for a long-range plan to develop economic self-sufficiency is neglected. Employment preparation is another: youth employment programs are not structured to be able to give many teen parents the extra attention they need, and typical teen parent programs provide education, health, and social services but do not provide for employment assistance. Family planning is a third example. Because of limited financial resources, most family planning programs provide medical services to young people but are forced to skimp on critical educational and counseling services.

Furthermore, because of the unpredictability of government funding, many fine programs start up and then close. This is costly in many ways. We lose the expertise that service providers have developed through experience in program operation. Also, creative and effective approaches are forgotten only to be reinvented in another place some years later.

What can we do, then, to help young people made decisions about their sexuality more wisely and to help families and youth-serving institutions meet the needs of young people more adequately? I assume this committee will be exploring this question in some depth. Let me just suggest that in general we must:

Improve approaches to help teenagers prevent or delay first births. We must provide support for families and other youth-serving institutions to help young people be sexually responsible, and we must make roles other than parenthood possible for young people to achieve. The role of parents, schools, and family planning services are especially critical.

Strengthen the organization of services to teen parents. We know how to help teen parents provide for their children and complete growing up. There are fine models available for service delivery and coordination. We must make it financially possible for communities to replicate these programs as needed. Employment assistance is particularly important.

Expand the recruitment of teenagers in need of services.

Provide for more extensive evaluation of program models so that effective approaches can be defined, publicized, and replicated.

Find more effective ways to challenge or counter the aggressive sexual sell of Madison Avenue. While it is difficult to assess the impact of the media, it is clearly

confusing for young people to be told that early or premarital sex is wrong while ads, movies, and music imply that sex appeal is critical to success in life.

Continue to explore the ways in which we prevent young women from developing their interests and talents.

Teenage pregnancy is a major public health problem. When we begin treating it as such I think we will find ways to meet the needs of adolescents more adequately so that they prevent pregnancy until they are prepared emotionally and financially to handle the responsibilities of parenthood.

Thank you for your time and interest. I will be glad to answer questions or provide you with additional information.

Mr. LEHMAN. We will hear from Dr. Wynne and Dr. Ellis, and then we will open it up for questions.

STATEMENT OF EDWARD A. WYNNE, PROFESSOR OF EDUCATION, COLLEGE OF EDUCATION, UNIVERSITY OF ILLINOIS

Dr. WYNNE. My statement will be in the record and appended to the statement are a half dozen charts. What I will do here is simply present these charts and comment briefly on them. The text in the record will cover it in more detail.

The first chart is about the main topic of this hearing, out-of-wedlock births, adolescents. Most of my data is about white adolescents.

I don't want to engage in discrimination against blacks, but to emphasize the broad-scale nature of this problem. While racial discrimination may be a partial root cause, it presumably is rather secondary, as we see from the data from 1955 to 1980.

There are two points, 1940 and 1950 which I didn't plot on the chart.

Essentially, from 1940 to 1980, the most recent year for which we have data, the rate of out-of-wedlock births to white females, age 15 to 19, increased 800 percent.

1940 is the earliest year we have got. As everybody has been saying here, we are at the highest point on record. I think the argument could be made that we are perhaps at the highest point since the first settlement of the continent in 1607.

In other words, the early data is down here (indicating chart). You see the chart would have to be quite a ways back and up to begin to equal our current rates.

I think that that is of some interest. Now, as I suggest in the text, I think this trend can be better understood if we also consider it in relation to some other patterns of adolescent conduct.

So the next thing I want to touch on is the adolescent suicide rate. All of you generally know that, in general, it has been increasing. However, while we have this kind of appreciation, we are not always cognizant of the long-range trends.

Now, as for long-range trends. This middle line (on the chart) is white males, 15 to 24. I deal with the 15 to 24's because those data go back further.

Obviously, 24-year-olds are not adolescents. If you take the 15 to 19, you have to start about here (indicating 1933 on the chart). We just don't have the earlier data in the bank.

Although, when the 15 to 19's are available, they generally parallel the 15 to 24's. So, in a sense, you can use the 15 to 24's as a proxy.

You can see that this middle line in the chart, which is white males, was somewhat high at the beginning, goes down for a long time. You get around 1955, and it begins to go up.

Up here (on the chart) is 1977. It is a high point that blips down a little at about the 1979. This is the most recent data we have available.

So you can say, these—the data for 1977 and 1979—are close together. Now, we may be fortunate to have it continue to go down. We will see. Although it has got a long, long ways to go.

The white female suicides are at a much lower rate, although actually their rates of change (compared to males) are approximately similar. Since they are starting from a much lower base, it is not as dramatic.

Now, with reference to the white males, the white males here in 1980 are 240 percent above the low year in about 55. They are 62 percent above the previous high year of 1914.

So, again, we have the figure that is at or near the highest point on record. I think the argument again could be made that we may be at the highest point since 1607, since, in general, these figures are somewhat associated with urbanity.

I am not saying that urbanization is the sole factor, but obviously the long-range trend has been for an increase in urban living.

So, we have this figure at the highest point. Now, in the case of females, there were somewhat higher periods of suicide if you go back to the early 1930's. In the case of males, we are at or near the highest point on record. In the case of females, we are quite high. In the case of males, perhaps the highest percent since the first settlement.

Now, another figure that is of interest—and I don't think it has received as much attention, actually—is the rate of death by homicide. I might mention that these figures about suicide and homicide are reasonably precise.

We can assume almost all deaths in the country are identified. The data eventually gets to some central point. In the case of homicides, we can assume that almost all of them are probably accurately classified.

You can appreciate that people want to be precise. There are a lot of implications to that.

In the case of homicide, white males—again, the 15 to 24's—have always had among the highest rates. But here in 1979, we have got the highest point on record.

Again, the low point is back here in about 1955. The white male rates have increased—let's see what we have got here—313 percent over the low point in 1955, and 50 percent over the low point in 1931.

In the case of females you have a somewhat similar curve, but from a different base.

Now, in all of these charts, I have also plotted the adult rates, which include the 15 to 19's . . . everyone. In all these cases, you see that in general the youth rate is climbing at a faster rate than the adult rate.

So it is not simply a phenomenon of general changes, although the adult rates change, but it is also a phenomenon of the youth being more severely impacted by whatever these factors are.

Now sometimes when I display these data, I use transparencies. I can't do it here, but it might be instructive if I just compared the suicide and homicide charts for a second.

You can see that in a gross sense there are certain parallels between these curves on the charts. If I use transparencies and put one on top of the other, you can see there is a certain similarity in their pattern. Indeed, there may even be a similarity between them and the out-of-wedlock curve.

Again, I would suggest that it is very likely the homicide rate for males is at the highest point possibly since 1607, again, on this urbanization theme.

Now, another piece of data are about arrest rates (indicating chart). Now, this is a little more involved.

We all realize that there are changes in what are crimes. So something now may be illegal that was not in the past, or vice versa. There are changes in police policies.

The police may get tough on something and informally they ignore it or formally they just wallop the kid and let him go and nothing ever went into the record, so that it is a little more problematic.

I might say all these data are corrected for the size of the youth group. So, if you have more kids, the data is weighted to allow for that.

But, in any case, the top line here (indicating chart) is 18 to 24. This is as far back as I have been able to get data. This is about—what is it?—1932.

So you can see in all cases there has been a steady rise. Now, in the case of the 18 to 24's, the rate of increase from—what is this?—this is about 1932—the rate of increase is 1,850 percent. That is 18 times higher.

Now, in the case of the persons under age 18, while the point of increase is not quite as high, the percentage of increase is quite notable because it starts from a much lower base.

So, allowing for the percentage of increase, you have a 9,300-percent increase in the rate of arrest for persons under age 18.

I might say this includes whites and blacks. That is the way the data are organized.

Again, you can see we have got this long-term trend of increasing rates of self- and other destruction, a sort of very coarse parallels between this and the earlier graphs.

Now, another thing that we are all very generally familiar with is the use of illicit drugs by young people. So, this is a little more recent, and is derived from the annual report put out by Health and Human Resources.

There has been a slight moderation (indicating chart) in drug use by adolescents. These data are based on seniors, the graduating class. So you get a slight drop, fortunately.

You can see, from the level of decline that you have got a long way to go until we get even down to here (indicating 1975).

According to the report, we—currently we have the highest rate of drug use among young people of any industrial country in the world. I think there is one interesting piece of data apropos of long-range trends.

In other words, here we are 1975. What was youth drug use like in 1965, 1955? Most of us are old enough to remember what it was like.

We don't necessarily need scientific statistics. There are some statistics that in 1962, less than 4 percent of the adults covered in the survey had ever used illicit drugs. In 1982, 64 percent had used illicit drugs.

So, we can again see this trend down here (indicating point off chart) someplace. I think also without qualification that this level around here (indicating 1978 in chart) is undoubtedly the highest point in our history.

Now, this is the high point, but you come down. You can see still we have got a long ways to go down.

Now, all of this has been about the conduct of young people. I think one of the things about it is we can sense is a dramatic correlation between these different patterns of conduct.

It is not surprising when more homicides are committed that there are more arrests. The arrests are also not only for homicides, of course, people who commit homicide, also wound people, they beat up people, they threaten people.

I might say that homicide statistics do not cover who did it. But as I go in some detail in my statement, there is a good reason to infer that, generally, the people committing these homicides are other adolescents of approximately the same social class and age group.

If homicide has gone up, it is not surprising that crime has gone up. It is not surprising that young people commit more homicides and crime use more drugs.

It is not surprising that young people who commit more homicides and crime and use drugs are also somewhat more vulnerable and prone to suicide.

Finally, it is not surprising that people who commit homicide, commit suicide, and use drugs are a little more prone to irresponsible sexual activity. There is sort of a logical relationship.

While people may differ about the accuracy of any one of these charts, they all seem to increase the credibility of each other. Now, one last piece of data that I want to touch on.

It is not about youth conduct, but just to remind us about some other long-term trends in the country. It is useful, I think, to keep these in mind, we muse, at least, about causes.

So, this graph is about other matters. One element of the graph is about per capita income in constant dollars; how well off is the average American, economically speaking.

This runs from 1929, and what the data show is what we all know very intuitively; the long-term trends in the country have been for individual personal income in constant dollars to pretty generally increase, as we understand.

Now, in the past 2 or 3 years there has been a slight leveling off. But the point of leveling off is at much higher than many of the previous eras in the history of our society.

All of us sort of know it, but I think it is useful to be reminded that we are relatively prosperous country. There are some individuals who are deprived, some individuals who are uncomfortable.

But, in general, most Americans are living better off than their parents and far better off than their grandparents. Presumably many of these young people involved in these episodes, since most of them are white, as I said, are among those living in this historically better off status, economically speaking. I am not so sure it is better off otherwise.

Now, the second point that I think is relevant, and that is this data portrayed on the graph, Government social welfare spending, Federal, State and local social welfare expenses as a proportion of the GNP. Education, welfare, health, social security, social services of that sort. I am talking about State and local, too.

We see that during the thirties it went up fairly high to about 14 percent of the GNP. Then it went down. Then there began a long-term increase.

There has been a recent decline, but even that point of decline, of course, is higher than any other period in our history. So taking these figures, we can say that never before in our history have Americans been so individually prosperous, never before in our history have our governments been spending more money on social welfare programs, and possibly, at least, never before in our history have our young people been so distressed in terms of conduct.

Now, I am not suggesting that these economic patterns are the principal, main, central causes of youth disorder, or anything of that nature. I am simply saying that those are things to keep in our mind when we talk about policy.

It appears that over the past 20 years, 25 years, some serious things have been going on in the environment around our young people, and the establishment of this committee is one of the many constructive steps we need to take to become more engaged in it.

Mr. LEHMAN. Thank you very much, Dr. Wynne.

[Prepared statement of Edward Wynne follows:]

PREPARED STATEMENT OF PROF. EDWARD A. WYNNE, COLLEGE OF EDUCATION, UNIVERSITY OF ILLINOIS AT CHICAGO

[References and figures at end of statement.]

There has been a long-term increase in the rate of out-of-wedlock births to American adolescents. This trend is portrayed in Figure 1.[1] That chart focusses on white adolescents to emphasize the general nature of the trend disclosed. In other words, the increase is not specifically limited to minority youths, or youths from poverty stricken families, but has affected even our supposedly advantaged white youth.

Obviously, the rate of white adolescent out-of-wedlock births is at the highest point since the beginning of national record keeping in 1940. In particular, the rate has increased 80 percent since 1940. Personally, I believe it is not only the highest rate on record, but also at the highest point in United States history. And, by "history," I mean since our first settlements in 1607—over 375 years ago.

This high rate is especially striking, since we all realize that the past twenty years have witnessed a great increase (a) in the development and distribution of contraceptive materials, (b) the sexual information made available to adolescents, and (c) the frequency of abortions. Twenty years ago, many "experts" probably assumed that such changes would lead to a decrease in out-of-wedlock births. Evidently, they were in error.

There are many different opinions about the causes and correctives for this remarkable and distressing phenomena. But, whatever one's opinion, debate and analysis can proceed better if we are more broadly informed about certain other important long-range trends in the conduct of American adolescents. Such trend information can help us to see the rise in out-of-wedlock births in a more complex context.

One of the most important—but sometimes ignored—trends of our times has been the steady long-term increases in the rates of self- and other-destructive conduct among American adolescents and youths. This presentation will (a) summarily out-

line these data, (b) suggest the relationship between the data and the rise in out-of-wedlock births, and (c) very briefly touch on possible causes and solutions. (In a number of earlier writings, I have reviewed the literature on causes and solutions, and presented a hypothesis of my own, which is shared by many other authorities.[2])

YOUTH SUICIDE

Figure 2 portrays the changes in the suicide rate for certain groups of U.S. whites between 1914 and 1979.[3] The beginning and ending years of the figure are the furthest back and most recent years available covering the age groups involved. Certain explanatory remarks are appropriate regarding the figure.

The youthful age group portrayed in the figure—those between age 15 to 24—is the youngest age group for which there are such long-term data. The younger age group—those aged 15 to 19—is not isolated in the data until 1933. And it is obviously desirable to be able to make the most long-range comparisons possible. The available statistics forthe 15 to 19 year group present curves which approximately parallel the 15 to 24 year group, although the rate of increase for the 15 to 19 group starts from a lower based point than the rate of 15 to 25 year olds. In other words, the overall suicide rate for the older group is somewhat higher, although changes in both rates have moved to a similar extent.

The figure shows that the rates for both younger males and females have increased at much faster rates than for adult rates. Furthermore, the young white male rate attained the highest rate on record in 1977, and has only slightly declined since that point. As for precise figures on the changes in the age 15 to 24 rates, it is noteworthy that in 1979, the young white male rate was (a) 240 percent higher than the rate in 1955, which was the previous low point, and (b) 62 percent higher than the rate in 1914, which was the previous high point (before the 1977 record). Thus, excluding the 1977 record, the current rate of suicide from young white males is at the highest point on record, and arguably at the highest point in history.

The suicide rate for young white females, although the base rates are lower, has increased at about the same rate as that of males. However, from about 1938 backwards the female rate was higher than it is now. And so there are (remote) historical precedents for the current high young white female suicide rate.

It is appropriate to recognize possible statistical anomalies underlying these data. In a modern industrial society like the United States, almost all deaths are officially recorded. Still, whether a death is classified as suicide is somewhat a matter of judgement. It is possible that the shift in youth suicide rates is partly due to changes in the classification process, as compared to being the result of a real change in youth conduct. Despite this possibility, several factors strongly militate against the shift representing largely a change in counting procedures. Figure 2 shows that the adult rate has remained relatively stable while the youth rate has increased; if there had been some change in judgemental policies, it would seem likely that both the youth and the adult rate would shift simultaneously. Again, judgements about causes of death, in our governmental system, are made by employees of many local units of government (e.g., coroners, medical examiners); while the policies of any one unit might change, it seems implausible to conclude that all of these thousands of local units and their employees have gradually changed their policies so as to generate a shift in suicide attribution regarding the young. Finally, as we will see, shifts in the suicide rate are paralleled by other changes in youth conduct trends; this supports the proposition that we have been witnessing a general change in youth conduct as compared to seeing the effects of a statistical artifact.

YOUTH HOMICIDE

Figure 3 presents the changes in the rate of death by homicide for certain age groups of U.S. whites between 1914 and 1979.[4] As in the case of the suicide data in Figure 1, the figure covers the longest time period and most recent years available. Also, the similar data for the age group 15–19 would essentially parallel the 15–24 age group, though the figures would run from a slightly lower base, and start from a more recent date.

The figure shows that the rates for both young males and females have increased at faster rates than the rates for adults—although the young male rate has historically been at higher levels than the rate for adults. The young white male rate attained the highest point on record in 1979. That rate was (a) 311 percent higher than the previous low year of 1955, and (b) 50 percent higher than the previous high year of 1931. The young white female rate (a) approximately paralleled that of young white males, though it started from a lower base, (b) was also at its highest

point in 1979. As in the case of the youth suicide rate, it is also arguable that the current youth rates of homicide are at their highest rates since our first settlement in 1607—since, like suicide, homicide is partly related to urbanization.

The death certificates do not tell us who are committing these increased murders. However, there are some bases for analyses. It is known that high proportions of violent crimes occur among persons known to each other. Therefore, it seems likely that many of the killers of the youthful victims are other young persons. It is also significant that in 1981, 43.7 percent of all persons arrested for murder or non-negligent manslaughter were under 25 years of age.[5] This means a disproportionately high number of homicides were committed by the young, as well as upon the young. The disproportion was generated in two ways. First, persons under 25 were a far lower proportion of the total population than 43 percent. Secondly, a high proportion of persons under 25 (i.e., children under 15 years of age) are likely to have committed very few homicides. Thus, youths between the ages of (let us say) 16 to 24 commit about 40 percent of the country's homicides; and evidently, most of their victims are their peers. We should further realize that many of the young victims were not persons who were randomly attacked, but young persons engaging in drinking, brawls, and other disorderly acts; such conduct is no excuse for their murder, but it does suggest that the murders partly are a measure of mutual disorder.

GENERAL CONSIDERATIONS

The homicide and suicide data presented above only run until 1979. However, the Department of Health and Human Resources does provide aggregated death rates for more recent years. These data are not comparable to the data underlying the graphs: they aggregate together males and females, persons of all ages, and whites and blacks. Still, they may have some indicative value. In any event, the national aggregated homicide rates for 1979, 1980, and 1981 are 14.5, 16.5, and 15.4 respectively; the comparable figures for suicide are 12.4, 12.8, and 13.0.[6]

It is significant that both the long-term suicide and homicide data are indirect measures of many forms of conduct not calculated in the death rates. The increase in measured suicides also reflects rises in the rates of undetected suicides, of attempted suicides, and of incidents of severe depression; similarly, the homicide rate reflects increases in attempted homicide, battery, and aggravated threats, and the generation of profound (and justified) personal fears in potential victims.

Incidentally, apropos of calculation, we should recognize the difference between changes in rates, compared to changes in absolute numbers. We can have situations where rates of disorder go down, while absolute amounts of the disorder rise—and we can have the reverse. Thus, at this time, the absolute size of the youth cohort is less than it was a short while back. As a result, the rate of youth disorder (which measures the proportion of disorderly persons among the young) might actually increase, while the total amount of disorder generated by the young might diminish. There is also another tabulation factor to keep in mind. There can be instances of decreases in the overall crime rates in an area, while rate of youth crime can still be rising. Such a pattern could occur when there were simply fewer youth around to commit crimes: thus, youths might be more prone to crime than in the past, but fewer crimes may still be committed. It should be evident that the instant paper is focussing on the rates of disorder among our young. The other measures just mentioned can also be relevant for some purposes. However, changes in the rates of disorders among the young are the best indicators of how well our youth-serving institutions are working.

RATES OF YOUTH ARREST

Rates of arrest are a problematic measure of conduct, since the rates may be affected by changes in police practices, or revisions in laws changing what conduct is unlawful. Still, substantial changes in such rates probably relate to changes in public conduct, as well as other policy changes. In any event, Figure 4 presents data about long-term changes in the national rates of arrest for certain age groups.[7] The groups are comprised of both males and females, and whites and blacks.

The data have been statistically weighted, to allow for changes over time in the sizes of the age groups involved. And 1933 is the earliest year for which national data are available, while 1980 is the most recent year available. The data disclose that between 1933 and 1980, the rates of arrest for persons aged 18 to 24 increased 1850 percent, and the rates for persons under 18 increased 9300 percent. The figure also discloses that the 1980 rate for persons aged 18 to 24 and under age 18 are both just below the highest point on record for these groups.

LEVELS OF YOUTH DRUG AND ALCOHOL USE

It is notorious that there has been a remarkable rise in the use of drugs by American youths over the past 10–20 years. The scope of the increase can be indicated by the following statistic: in 1962, less than 4 percent of the general population had ever used an illegal drug; by 1982, the percentage of "ever users" had risen to 33 percent among all persons over 12 years of age, and to 64 percent among high school seniors.[8] This rise has moderated in the recent past. Figure 5 summarily presents the key data on youth drug and alchohol use from 1975 through 1982.[9] These data are based on annual anonymous national sample surveys of the high school graduating classes for the years indicated.

It is encouraging to realize there has been some decline in drug use. Unfortunately, the Department of Health release on the most current data observed that American youths "still have the highest levels of illicit drug use to be found in any nation in the industrialized world."

TYING THE STATISTICS TOGETHER

Taken in toto, the statistics show a high degree of internal validity. Whatever technical questions can be raised about the accuracy of any particular graph, all of the graphs portray relatively common patterns, and each reinforces the credibility of the others. The data do not mean that all—or almost all—American adolescents and youths are engaging in gross disorder. We are a large country, and there are surely millions of wholesome and effective young persons. But, at the same time, it is important to recognize that the proportion of disorderly youths, who hurt themselves, and victimize others, has been steadily growing.

The relationship between adolescent out-of-wedlock births and the other statistics presented is rather evident. It is not surprising that a group of persons displaying rising rates of suicide, homicide, delinquency and drug and alcohol use show a propensity to develop irresponsible sexual relationships, and bear out-of-wedlock children. Indeed, given the rising self- and other-destructive conduct, it would be naive to expect such youths to display sexual responsibility. Furthermore, one might also expect that "programs" narrowly directed at preventing pregnancy might not be too effective, since they are bucking a number of other powerful and destructive social trends.

CAUSES

The wide-spread and distressing trends just pesented invite a general—although very truncated—consideration of possible causes and solutions. First, however, certain potential causes must be mentioned and tentatively put-aside.

One cause sometimes alleged for the trends has been the underfunding of government social welfare programs, and the generally poor state of the economy. But, when we look at long-term conduct statistics, it is also wise to consider long-term economic and programmatic trends. Figure 6 presents long-term trends (up to the most recent years available) in (a) individual per capita income in constant 1972 dollars, and (b) federal, state and local social welfare expenses (health, education, social security, welfare) as a proportion of the GNP. [10]

As we all know, the long-term trends have been for these figures to substantially rise. These rises, over the past 20 to 30 years have roughly parallelled the climbing rates of adolsecent self- and other-destruction. It is true that, in the past few years, the rates disclosed in Figure 6 have slighly declined. However, the current levels of personal income and social welfare expenses are still far, far above the levels of the late 1950's; and yet, during the 1950's, the degree of youth disorder was far less than at present. It would be simplistic to contend that there has been a direct relationship between these rising rates of funding and personal income and youth disorder. But, it also might be simplistic to contend that more funding is a significant solution—since the rates of disorder kept rising over the years during which incomes and funding continuously increased.

It has also been argued that the increases in youth disorder were largely due to the "youth bulge"—the disproportionately high ratio of youth-to-adults resulting from the maturation of the World War II baby boom. There were just too many young persons (compared to adults) for the country to swallow. Unfortunately, we are several years past the end of the youth bulge, and youth disorder has not improved much. Furthermore, a colleague of mine and I statistically tested the relationship between the adolescent suicide rate and the proportion of adults to youths in the society (over a fifty-year period). [11] The analysis concluded that the statistical relationship between the youth suicide rate and the proportion of adults to

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youths was very slight; in other words, our study did not substantially sustain the youth bulge hypothesis. Historically speaking, our conclusion is not too striking. During the earlier periods in our history, the youth/adult ratio was often much more "unfavorable" than in the recent past—at the time of the American Revolution, half our population was probably under fifteen years of age. The issue is probably not the raw ratio, but the social structures which foster constructive youth/adult interaction. In those structures exist, a small number of adults can have a great effect; if the structures do not exist, large numbers of adults can be ineffectual vis-a-vis the young.

Another explanation for the rise in youth disorders is that many pervasive, incremental changes in adult and youth environments have transformed America into a poor place for rearing emotionally wholesome young adults. The data I have just presented are important evidence in support of that conclusion. I am editor of a newsletter, Character II, which essentially supports the incremental change position. Included among Character II's board members are prominent academics such as Urie Bronfenbrenner, Cornell University; Donald T. Campbell, Leigh University; James S. Coleman, University of Chicago; David Riesman, Harvard University; and Ernest van den Haag, New York University.

Some of the major elements of our perspective are suggested in the following quote from our Statement of Policy:

All persisting human societies have made great efforts to ensure that their children and adolescents—the future of the society—are trained to support their central values. As Plato said, over two thousand years ago, "training and education are what the overseers of the city must watch, and take care that they are not corrupted insensibly. They must guard them beyond everything . . ."

In our democratic society, the word "character" is often used to describe traits that relate to America's central values. These traits include persistence, tact, self-reliance, generosity, and loyalty. There are many signs that America is becoming less effective in transmitting such traits to its children. This is understandable. A large, dynamic, materialistic, and prosperous society may not be an ideal environment for developing these traits. Indeed, a significant number of both social scientists and laypeople have concluded that we are failing to give adequate attention to the many forces destructively affecting character formation in our young.

Character II's board members necessarily have somewhat different perspectives on the matter of causes and solutions. Still, we generally believe that some important causes of our current situation are as follows:

The general devaluation, in our society, of the importance of properly rearing children and adolescents.

The excessive reliance on formal institutions and institutional employees to handle child-rearing and adult/youth relations.

The high value we currently place on adult self-fulfillment, to the detriment of themes such as unpaid community service, parenthood and family obligations.

Our general reluctance to hold young persons to significant personal responsibilities, or make them accountable for misconduct.

The many changes which have occurred in schools, colleges and social agencies, which make them less effective at transmitting (or sustaining) appropriate values to children, youth, and families.

The long-term rise in general affluence, which has lessened the economic significance of children and adolescents to families (and has made parents less concerned with rearing competent children).

Demographic developments, such as the decline in family size, the increase in single parent families, and the closer age-grouping of children in families, which have lessened the interactive experiences available to children.

The long-term decline in farming families, and the rise in urban and suburban populations, which have put more children in less wholesome growing environments.

The increasing exposure of children and adolescents to the media, and the unwholesome nature of much of the material presented.

SOME TENTATIVE SOLUTIONS

The matter of proposing corrective steps is obviously problematic and controversial. Still, there are some measures that probably all Character II, board members would support:

1. The federal government should issue and broadly distribute some simple, clear publication presenting the basic information about trends in adolescent self- and other-destructive conduct. At this time, these data are buried in obscure government

reports and are hardly even available to experts. Unless the facts are generally and clearly known, little intelligent discussion can occur.

2. Some government agency should commission a group of experts to write a series of essays or papers, discussing the implications of the data, and provide for the distribution of these writings.

3. The federal government, or other legislative agencies, can do little to explicitly regulate personal values. However, we realize that moral values underlie many of the legislative issues which confront the Congress. By the laws and appropriations you pass, you express your opinions about what is right for individuals and families in our country. And individual citizens and families often reconsider their own beliefs and conduct in the light of such laws, and the debates which arise around them. More legislators should recognize that we obviously have been making serious mistakes in the policies we have been applying around our children and adolescents. We should recognize the need for what might be called social reconstruction. Such a shift will have many implications for day-to-day legislative conduct.

4. There is obviously need for broadened research about the causes of the youth conduct changes I have been describing. Speaking summarily, we know little or nothing about what sorts of youth have been involved in the changes, nor about what kinds of family or community backgrounds have enabled many youths to resist the destructive trends. Such research is important in developing more wholesome policies.

5. There has been a long-term trend in America towards applying more uniform policies among our communities and institutions. The trend has been advanced to encourage certain public policies, and foster various economies of scales. The trend has made us a more homogeneous society. This homogeneity makes it harder for us to engage in various forms of social experimentation, to see what "solutions" to our youth and social problems work better than others. Indeed, it is even possible that some of our current uniform policies are partly advancing destructive ends. In the light of the grave deficiencies which exist, we should be more willing to encourage (to tolerate) more diversified, localized approaches to many youth-related problems. Our national solutions have not displayed a particularly good track record.

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Fig.1

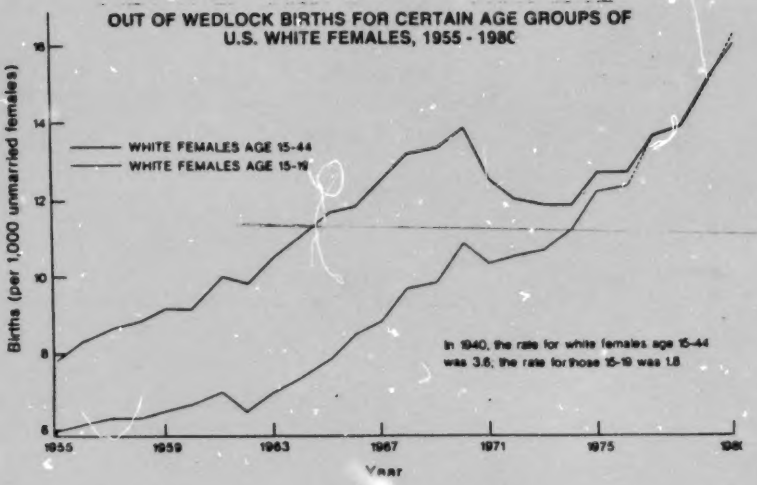

OUT OF WEDLOCK BIRTHS FOR CERTAIN AGE GROUPS OF
U.S. WHITE FEMALES, 1955 - 198C
WHITE FEMALES AGE 15-44
WHITE FEMALES AGE 15-19
Births (per 1,000 unmarried females)
In 1940, the rate for white females age 15-44
was 3.8, the rate for those 15-19 was 1.8
1955
1959
1963
1967
1971
1975
Year

Fig.2

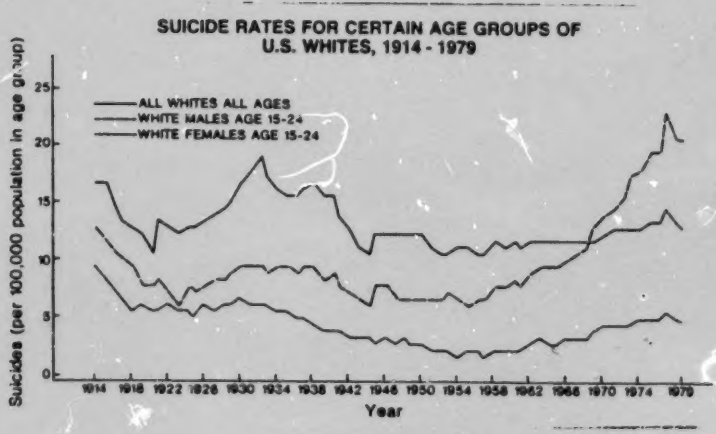

SUICIDE RATES FOR CERTAIN AGE GROUPS OF
U.S. WHITES, 1914 - 1979
ALL WHITES ALL AGES
WHITE MALES AGE 15-24
WHITE FEMALES AGE 15-24
Suicides (per 100,000 population in age group)
1914 1918 1922 1926 1930 1934 1938 1942 1946 1950 1954 1958 1962 1966 1970 1974 1979
Year

Fig. 3

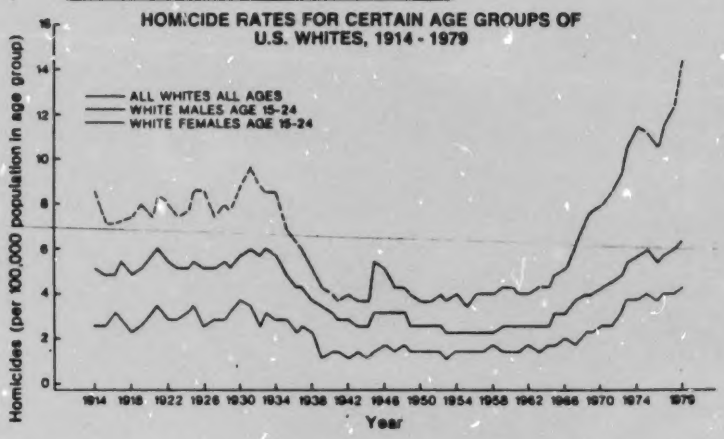

HOMICIDE RATES FOR CERTAIN AGE GROUPS OF U.S. WHITES, 1914 - 1979
ALL WHITES ALL AGES
WHITE MALES AGE 15-24
WHITE FEMALES AGE 15-24
Homicides (per 100,000 population in age group)
0
2
4
6
8
10
12
14
16
1914 1918 1922 1926 1930 1934 1938 1942 1946 1950 1954 1958 1962 1966 1970 1974 1979
Year

Fig. 4

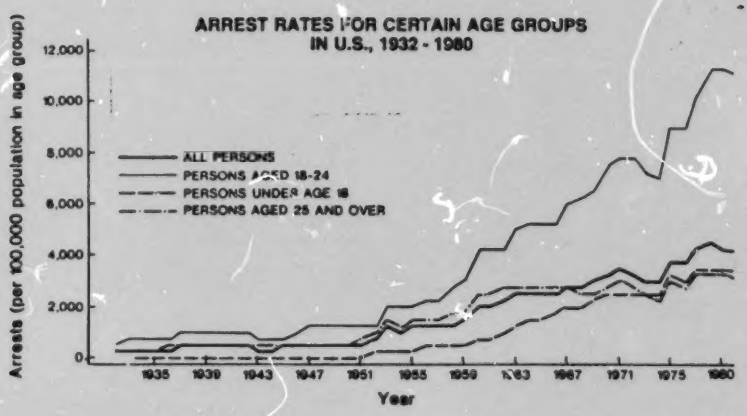

ARREST RATES FOR CERTAIN AGE GROUPS IN U.S., 1932 - 1980
ALL PERSONS
PERSONS AGED 18-24
PERSONS UNDER AGE 18
PERSONS AGED 25 AND OVER
Arrests (per 100,000 population in age group)
0
2,000
4,000
6,000
8,000
10,000
12,000
1935 1939 1943 1947 1951 1955 1959 1963 1967 1971 1975 1980
Year

Fig.5

DRUG USE BY HIGH SCHOOL SENIORS
1975-1982

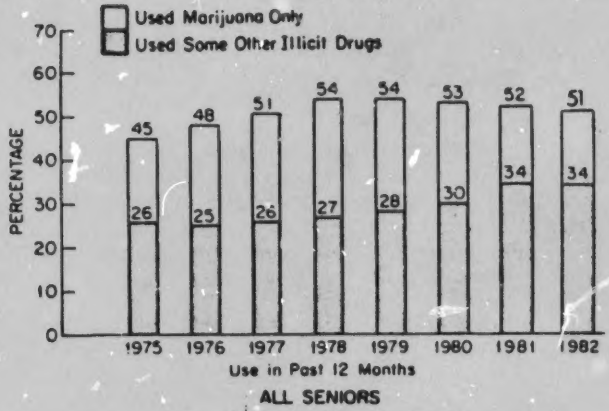
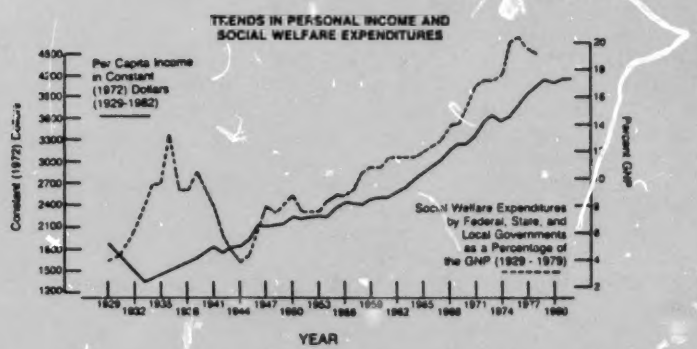


Fig.6



Mr. LEHMAN. Dr. Ellis, please.

STATEMENT OF EFFIE ELLIS, M.D., HEALTH CONSULTANT, QUALITY OF LIFE PROGRAM, DEPARTMENT OF HUMAN SERVICES, CHICAGO; HEALTH CONSULTANT, MARCH OF DIMES

Dr. ELLIS. Thank you, Mr. Chairman, and members of the task force. I would like, first, to thank you for the opportunity of being here with you, and I would also like to thank you for having interest in this problem.

I believe that at the present time teenage pregnancy is a problem in our country which is causing dissolution of many of the threads in the entire fabric of our society.

I have written in my statement about the problems that have been mentioned here this morning. As a physician, I suppose I should say a word about the fact that teenage pregnancy is in a large measure responsible for the high infant mortality rates, and also for the high infant morbidity rates.

This would mean damage to our babies in the latter instance. We all know that we have a large number of babies, the small birth weight babies that Dr. Baldwin and all of us have mentioned here today, and the panelists have talked about, but it is in this group of babies that we have large numbers of problems in the physical area like mental retardation, cerebral palsy, reading and learning disabilities and things which limit the child's performance as the child passes through the various stages of life.

We all know the expense that this brings to society and the pain which it brings to the parents. I have worked in teenage pregnancy for perhaps 35 years.

I have worked with all segments of the population, the rich, the poor, the white, the blacks, and I believe, as was said by many of the panelists this morning, and the members of the task force, as well, that the outcome really depends upon the relationship of the individual to the environment, and whether or not the child has appropriate supports.

Now, we do not just become an adolescent overnight. This is a problem that we don't seem to be able to put together.

I was very happy to hear about the adolescent problems from my colleague here because we seem to isolate each one of these problems, and we do not realize that adolescence is a stage of life and that the adolescent has certain tasks to perform in order to become an adult.

One of the important tasks of adolescence is growing toward maturity. The other is getting accustomed to one's physical body and understanding every aspect of it, the sexual, as well as the other.

One of the other important things is gaining independence. As we grow toward maturity, it is necessary to have a set of values.

These frustrations and imbalance in this leads to many of the problems which we have, together with the fact—it has been said repeatedly—the supporting environment may not be adequate.

I would like to call your attention to this ecological piece, which simply says, in effect, that life is a continuum, and it is impossible to just start any place and not look at what has gone before.

We think of the continuum as starting with the intrauterine environment within the womb. I want to point out that many problems in adolescent pregnancy come about because of the new morbidity, which Dr. Wynne talks about, of the new lifestyle influence on the development, and this occurs early.

Take the adolescent whose body does not provide the appropriate environment for the baby's development. Many birth defects, many low-weight birth babies, many malnourished mothers, nonprotection of the brain.

I want to emphasize this because in the intrauterine environment, we hope to keep the baby in long enough for the brain to go through appropriate development. You see, this is one of the things that does occur.

The second environment is the environment of birth. I am not going to belabor this. I want you to see. Many of our children do not have access to the best kind of care.

Let me point out that if we look at the levels of need, those girls who are not poor would probably have excellent prenatal care, excellent care at birth, but they need a different kind—when the baby is born, the mother still goes on and her emotional development has a great deal to do with the way the child develops.

I wanted to put that in place. It is a no-win situation, although there are different things to consider. Of course, the third environment is the family, the school, the community organizations, and so on.

I would like to just briefly talk about the situation of some of the most vulnerable children.

Mr. LEHMAN. Excuse me, Doctor. We are going to have to go vote now, and come back. If you could summarize in maybe 2 minutes.

Dr. ELLIS. I will try.

Mr. LEHMAN. You will have about 2 minutes, and then we do have to run, and then we will come back for questions.

Dr. ELLIS. All right. I don't know what I can say except only to talk about these vulnerable children, and to talk particularly about the male because there is no pregnancy without the male, and I wanted to point out some of the things that are being done in the vulnerable areas to address this problem.

It is in the report, in part, but just let me summarize by saying, in talking to the males themselves--and this has been very hard to do because while we have talked about sex education in the schools from a practical point of view, it has been around the menstrual period, the menopause in the main, and we have not talked about the natural history of sexuality of the male in any place that has been too effective, neither in the schools, nor in the physician's offices or anyplace else.

It is becoming more common now. The male, therefore, does not understand his own sexuality. So we have to try to learn how to communicate with them.

But I want to point out that they do blame the girls for a lot of the problem. I was in a situation the other day, I was talking to two or three males, and they said that the girls want to become active at 6, 7, and 8 because they are viewing television and listening to the songs and music and think that they are abnormal if they are not sexual beings.

With that, we can close. We can take up any questions that we have later. Thank you, Mr. Chairman.

Mr. LEHMAN. We will be back in about 5 or 6 minutes, and then we will open it up for questions.

[Recess.]

[Prepared statement of Dr. Effie Ellis follows:]

PREPARED STATEMENT OF EFFIE O'NEAL ELLIS, M.D.

It has been said again and again by numerous people at all levels of society that teenage pregnancy, teenage parenthood and fatherless households cast a deadly shadow over present and future generations. Indeed, teenage pregnancy has become a malignancy on society, which threatens to destroy much of the existing social fabric. It is not teenage pregnancy alone, but the related problems, as well, that act together to bring about devastating results.

The health and social consequences of teenage pregnancy are for the most part unfavorable or harmful. Teenage pregnancy carries substantial health risk for both mother and baby. For young teenagers (and now-preteenagers) the risks are greater.

Babies born to teenage mothers are much more likely to die in the first year of life than those born to mothers over 20 years of age.

More low birth weight babies are born to teenage mothers. It is in this group of low birth weight babies that mortality are morbidity rates are highest.

Fifty percent of teenagers receive no prenatal care during the first trimester of pregnancy.

There is a higher incidence of toxemia and anemia in young mothers.

There are higher risks of complications during labor for the younger mother.

The risks of maternal deaths are higher for young teenagers.

Serious as they are, the health consequences are only part of the picture. The untold social consequences may well be more critical.

Teenage pregnancy has the potential to destroy the family unit as we know it.

It is highly probable that a teenage mother will bring up a child in a home with no father present. Even if marriage takes place teenage parents are more likely to separate or divorce than those who delay child bearing.

Teenage pregnancy often initiates a never ending cycle of dependency with many attendant problems.

In answer to the question "what do you do to prevent pregnancy,?" a second youth said, "We will say she can use somehing, but not us."

Still another youth said, "A man is supposed to have sex but he is not supposed to shed his seed upon the water. He's supposed to have a woman who can give birth. That's my religion."

The black urban ghetto truly is an arena of human agony. For the most part, quality of life is extremely poor. Excessive loss of human potential is occurring in all developmental stages. This latter is understandable, as Dr. Cheri Steele states in her doctoral thesis, ". . . because in the black ghetto there are excessive numbers of (1) dysfunctional families, (2) ineffectual parents as role models, (3) poorly disciplined young family members, (4) large numbers of young parents of teenagers who are products of teenage parents, (5) high adult and teenage unemployment, especially male, (6) large numbers of female headed households, (7) lack of job skills, (8) excessive amounts of risk-taking behavior, (9) poor environmental circumstances, (10) poor housing, (11) lack of work skills, (12) poverty or marginal existence, (13) poorly established personal identity and low self esteem."

Venture to predict that if the present urban trend in teenage pregnancy continues at the present rate, the large under-priviledged black ghetto will continue to decay. Catherine Chilman has repeatedly reminded us that there is a need for further research on teenage pregnancies in the population at large.

What can be done to prevent or decrease teenage pregnancy? The answer is complex. This is because our knowledge about the problem and about ourselves as humans is increasingly complicated. Our attempts to deal with bits and pieces are outstripped by rapid change accelerating high technology and increasing specifications.

There is an interdependence or ecology of human issues. So what we view as a simple, single teenage health and behavior problem is intricately woven into the entire fabric of adolescent and family life.

It is impossible to work on teenage pregnancy in isolation from the developmental tasks of adolescence, the nurturing capability of family, and the capacity of commu-

nity institutions to provide supportive services. There are no piecemeal solutions to these problems.

Human development is a continuing process from conception through senescence and death. In the process of becoming an adult an individual lives in and passes through a number of environments, and each environment helps to shape what the individual will become.

In sequence, these environments are the intrauterine environment, the environment of birth, the family and home environment, the school environment and the physical environment. All of these environments are interrelated and should meet certain standards to maximize the quality of life.

In considering teenage pregnancy we must first think of whether or not the mother is old enough or healthy enough to provide an environment that is safe for the growth of the baby. Does the environment provide what is needed for the babies' development? Is the environment free from disease, drugs and other pollutants that can cause harm?

Secondly, we must determine how well the pregnant girl has come in performing the tasks of adolescent development. Is she moving toward maturity in an orderly fashion? What are the social influences that impact strongly on her behavior? How does she relate to peer group pressures?

Thirdly, the involvement of the father of the baby; the level of his maturity and responsibility is important to the successful outcome of a new family. Dr. Arnita Young Boswell, Consultant, Chicago Department of Human Services and Coordinator of the Family Resource Center—Family Management Program—is using the SOAP OPERAS to stimulate social and emotional adjustment, positive self concepts and family relationships.

Finally, the families of the expectant mother and father must be brought into the picture. Programs should be developed within Housing Project Areas for teenage and young adult fathers. A pilot program, currently under development by Dr. Arnita Young Boswell and Rick Pullin at the Family Resource Center, Family Management Program of the Department of Human Services. While traditionally much public attention has been focused on the unwed teenage mother. The teenage unwed father virtually has been excluded from the family picture.

Dr. Leo E. Henricks, senior research associate at Howard University's Institute for Urban Affairs and Research in Washington, D.C., has studied large groups of teenage fathers and believes thast the attitude toward fatherhood for most young fathers seems to show concern for both the mother and child. Further, 96 percent of the fathers surveyed expressed concern for the future of the child, and 80 percent saw nothing wrong with having a child out of wedlock.

Dr. Erwin A. France, Program Director for the Male Adolescent Program, sponsored by the Alpha Phi Alpha Fraternity and the March of Dimes-Birth Defects Foundation, believes that there can be no large scale prevention of teenage pregnancy without the full cooperation of the male. Under Dr. France's leadership, several Alpha Chapters in various sections of our country have developed programs to:

(1) Acquaint a selected group of young black males with the serious negative consequences of adolescent pregnancy through conferences on Adolescent Pregnancy.

(2) Develop a cadre of such youth, affiliated with community-based organizations who can (with the help of their adult sponsors) transmit such information to their peers in order to develop remedial local programs.

(3) Gather information on how adolescent males feel about this problem and solicit their views on how this matter can be addressed on a local level.

Discussions of adolescent motherhood have suffered on at least two counts. First, when talking about teenage parents we tend to assume that all young mothers are the same. We look at infant mortality rates and forget that most children of young mothers survive, some healthily, some not. We consider the number of mothers on welfare but do not examine why some are not dependent on the State. We note the number of school failures but do not try to comprehend why many others succeed. No two teenage mothers are alike, no two face the same problems, no two respond in the same way to intervention, and no two raise their children in an identical fashion. Secondly, we now look at adolescent parenthood as an issue unto itself. Twenty years ago intervention with pregnant teenagers was considered only one strategy in a larger War on Poverty. Today, that war is forgotten, and we tend to ignore the broader social context when we analyze this issue.

To redress these two problems, our understanding of adolescent motherhood must be set in an ecological context. By ecological context I mean that the young woman who becomes pregnant and bears a child does so within the milieu of her own family, her neighborhood, her culture, and her society. The family, neighborhood, culture, and society each influence the responses the adolescent must make as a

parent. This point of view is espoused by Dr. Harold Gershenson whose recent work has examined how variations among families and social networks effect a teenager's ability to function as a parent. For example, whereas we often think of the girl's mother as a source of support to the teenager, this mother may be the source of the problem. Some teenage parents might be well able to care for their children if they did not have to care for an alcoholic or schizophrenic mother at the same time. By focusing only on the teenager as a parent, but not as a daughter of an alcoholic we miss half of the issue.

An ecological perspective insists that while keeping family differences in mind, we look outward to other levels of society. Adolescent motherhood may be an entirely different experience for two girls of the same race, and the same class who reside in the same city because one lives in closer proximity to a health clinic than the other or because one attends a school where the principal is sympathetic to her needs and the other does not. In other words, the administrative arms of the society, the health, educational, welfare, and legal systems help formulate the problem and direct possible responses. As such, the components of the ecological system can easily come into conflict. An example is the well-intentioned WIC program. This program provides additional food for mothers, often teenage mothers, and their small children. Yet, a teenage mother in the WIC program may live in a family where others are hungry. Should the adolescent drink the extra milk herself or share it with her little sister? The law says she should drink while the culture teaches us to share.

This example demonstrates not only how elements of the ecological system can come into conflict but why we must proceed to look at the broader levels. How can we expect the WIC program to succeed if we do not address the issue of hunger in the United States? Can we be concerned about nutrition for pregnant adolescents if we are not concerned about nutrition for their families? Similarly, can we expect job training to be effective if no one in the community can find a job?

The problem of adolescent motherhood cannot be separated from the broader issues which confront our society and our nation. Indeed it is difficult to deny the teenager's desire to "live for today" when we all face imminent demise in the form of a nuclear disaster.

SUGGESTIONS FOR ACTION

Numerous approaches must be tried if we are to meet the needs of teenage pregnant girls, teenage parents and their families.

The problem should be revisited within an ecological framework.

Give strong support to the development of programs for teenage and young adult males.

Support the development of less conventional programs within the community to encourage youth participation and provide the opportunity for youth to "try on things for size," so to speak.

Seek improvement in administrative methods in order to 1) reduce staff paperwork without reducing efficiency. (Pressuring staff to do so much paperwork decreases enthusiasm). 2) Permit innovative approaches immediately when expected results do not accrue.

Support and seek funding for the ideas suggested in "A Policy Framework for Racial Justice" by the Joint Center for Political Studies.

Utilize the arts to gain interests of the teenagers as well as to help demonstrate their talents and reinforce self worth. A good example is the "Great Nitty Gritty" by Oscar Brown, Jr., in which the actors are young people from the inner city.

Increase access to a continuum of health care.

Increase services which help provide basic personal necessities (food, clothing, shelter and financial assistance).

Increase child care for infants and young children. Night care is needed as well as day care.

Comprehensive family planning services involving teenagers and senior citizens as part of the educational staff.

Mr. LEHMAN. We will go forward with the questions now.

I would just like to ask one question to Dr. Ellis. I was interested in the male aspect because I saw a movie over the weekend, and it sounded like a trashy movie, but it was a very worthwhile movie. It is called "Puberty Blues", and it was filmed in Australia.

Have you ever heard of it?

I went to it because it dealt with this very problem. In that movie, in order to gain status with the teenage males in Sydney, Australia, the females had to become sexually permissive in order to be with the group that wasn't beat up on on the schoolbus, in order to be part of the group on the right beach, in order to be with the group that wasn't looked upon as nerds.

The women were much more compliant, and the males were setting the ground rules in regards to teenage sexual activity. I just wondered if you wanted to expand on that a little bit?

Dr. ELLIS. You always have a way of saying just what you said. In this instance, you have as well said this.

I think in many areas of our cities, the same kind of thing is obtaining. The young men have to engage in sexual activity in order to prove that they can belong to a group, a gang, a club.

The women are doing this more and more.

Mr. LEHMAN. And not enjoying it, according to this movie.

Dr. ELLIS. Yes. To say that it gives them a feeling of belonging.

I did want to make the point that when young people are not a part of the main activity of society, they do all kinds of things to call attention to themselves.

It is not uncommon to see young women talking about me and my kids. This is the passport to respectability for them, without understanding much of the other that is going to happen.

Mr. LEHMAN. Thank you very much. Dr. Wynne, I notice in your data one of the pieces of data you left out was accidental death. I just wonder if that particular data is available and whether you think it has any correlation with some of this other data you had.

Dr. WYNNE. I am not as familiar with that. My impression is that the long-term trend has been also for a rise in accidental death, although I can't quote the rates, as I can in these others.

It is not too hard to surmise correlations, that people are drinking and driving, under the influence of drugs, et cetera. I also suspect that at least a moderate number of suicides are classified as accidental deaths because of reasons we all understand.

So I am pretty sure there has been an increase. I don't know the rates. We can see the potential relationship.

Mr. LEHMAN. I have another question for you. In comparatively affluent countries and societies similar to the United States—I mentioned Australia, which is not much different, South Africa, perhaps Canada, and Britain. Basically their societies are not that much different than ours——

Dr. WYNNE. Well, they are somewhat different, but there are some parallels, if I may qualify.

Mr. LEHMAN. What I am trying to say, is there anything highly divergent between the data you received from those countries, of those nations, and what we are seeing in this country? Are we aberrant?

Dr. WYNNE. Aberrant is a very apt word, yes.

Mr. LEHMAN. Where are we different, apparently largely different, from other societies similar to ours throughout the world, if there is a real difference?

Dr. WYNNE. There are some differences. For example, most of us recognize through the media that upper middle class youth unrest,

demonstrations, riots, terrorism, is a worldwide phenomenon. We see it in other countries.

I read an article by James Wilson, who is a respected authority. He said the data in England showed a long-term rise in juvenille delinquency within that country.

I had done some little research on suicide and homocide trends, and the increases in those matters are not as dramatic in those countries as in America. So that to some extent, we are, at least, moderately aberrant.

On the drug use, again, our level of drug use is higher than in other industrialized countries. So we are, you might say, somewhat in the lead.

Mr. LEHMAN. Unfortunately. I just have a question for Ms. McGee. How do you make teenage parents economically self-sufficient and give them self-respect? Are any programs that you know of really working without being highly subsidized?

Ms. MCGEE. The kicker was the last part of your question. Without being highly subsidized.

Mr. LEHMAN. Yes.

Ms. MCGEE. Do you mean without putting extra moneys into extra new programs?

Mr. LEHMAN. Right. I mean, to what extent subsidized.

Ms. MCGEE. I think that we need subsidies, for sure. By that I mean public moneys that are targetted at teen parents who are most likely to be unable through the existing network of services to prepare themselves to work.

We have fine models, many of which were funded under CETA originally. One of the models (that has not used CETA money, actually) that has been getting a lot of attention recently is project redirection, which had Ford money and public moneys.

We know the components that those programs should include to make sure that young women and young men develop the kind of attitudes and skills that would enable them to enter the job market successfully.

But I don't think that we can do that without special programs that do cost additional moneys.

Mr. LEHMAN. I want to thank this panel for being with us today. We will certainly keep in touch with you. We appreciate your being here.

There is a debate on the floor. Perhaps Congressman Bliley will have some questions, and I would like at this time to turn over the meeting to Mr. Bliley, who will ask you questions and then adjourn the meeting until 1:30. Thank you again for being here.

You will have to excuse me for a little while.

Mr. BLILEY [presiding]. Dr. Ellis, you made mention of the need for our teenagers to become sexually responsible. Would you please tell us what, in your opinion, is a sexually responsible decision for a youngster under 16 years of age?

Dr. ELLIS. I would think that a responsible decision for a child under 16 years of age would be not to have sex. But I know when I say that that the influences which impact so heavily on the young people make this unlikely in a large number of instances.

There is no place where the kind of growth and developmental guidance within this ecological framework that we are talking about is available to large number of our children.

We talk about isolated information in a time of need, when we must find ways of giving information appropriate to age. The teaching of sex to a child begins the day it is born.

There should be guidance by the person giving care to that child and the mother and the father about what the child's development is like and what the child is as a person.

This should continue in an appropriate way throughout the child's development. There are significant things that need to be considered here.

For example, in the first year of life, a child should learn to love, a child should learn trust, a child should learn limits, a child should learn respect. As one goes along, respect for difference, both agewise and cultural and racial.

Now, how do we do this? Well, we have to teach the parents. Parents are paying large amounts of money to get certain care.

Part of the trouble has come in the fact that we talk about health when we mean medical care. The health of an individual would have to consider the development of all of the dimensions of a human that have to be in equilibrium, in balance, in order for the individual to be truly healthy.

I think that this is the kind of thing that our children need all along the way, and that we must begin to try to provide. So that when the environment impacts, they have the capacity to analyze and see what is being done.

I wanted to talk a little bit about the terrible plight of the more vulnerable members—I think this is what we have all been making a plea for—who have teenage parents themselves who do not know any of these things, and they do not have access to ongoing, continuing care.

Because what we have done, for awhile, if we have got the baby out of the uterus and the baby was a healthy baby when we got the baby out, that was the end of support and care for that mother.

You see, there has been a discontinuity. To summarize, let me say, I think we could do a whole lot if we respected each other, as we have here, and worked together within a social, environmental, educational frame of reference on all of these complex problems.

I think herein lies the challenge.

Mr. BLILEY. Thank you. Ms. McGee, you stated that marriage during the teen years means, among other things, a greater likelihood of having a large family in an unstable marriage. I found it interesting that you lump these two together.

Could you please tell us how the size of the family and the instability of marriage relate to one another?

Ms. MCGEE. I think that that sentence, which I actually didn't read here, says "marriage during the teen years, especially during school age years, means a greater likelihood of dropping out of school, of having a large family and of an unstable marriage."

I am simply summarizing the research data. I don't think that there is a cause/effect between those two things. They are simply consequences of being young and making a marriage probably prematurely.

I didn't mean to imply—I don't think this sentence does—that an unstable marriage leads to a large family or vice versa.

Mr. BLILEY. I was just confused when I was reading your testimony last night. This jumped out at me and I just want to find out——

Ms. MCGEE. This part of my testimony is just summarizing what we know, which is that young people who get married and have kids at a younger age are more likely to have these kinds of patterns.

I think the information on that research is probably better directed at Dr. Baldwin.

Mr. BLILEY. In the statistics you have concerning the disadvantages in instability of early marriages, do you make a distinction between those who marry because the young woman is already pregnant and those who marry because they want to begin a family?

Ms. MCGEE. Again, I would have to defer to Dr. Baldwin as to more information about that study. But, yes, I do believe from what I know that girls who make marriages because they are pregnant are far more likely to have those marriages not last.

That is my understanding of the research.

Mr. BLILEY. One last question; you state that a very few women experience any long-term difficulties after an abortion. Furtner, that those who do usually had some emotional problem before the abortion.

Could you tell us what you base those figures on?

Ms. MCGEE. All of the studies that are done of the long-term effects of abortion have substantiated that conclusion. Women in general—not just young women—women who have had trouble with having had an abortion were women who prior to the abortion were already having emotional difficulties. That the abortion itself was simply perhaps a traumatic event in a life that was already troubled. Abortion as an event in the life of a woman who is having average life experiences is not a traumatic event.

Mr. BLILEY. Dr. Wynne, you state that the Federal Government has been making big mistakes in the policies it has applied to children and adolescents. Apparently you see these policies being in some way a cause of our problems with adolescents.

Could you be a little more specific, especially with relation to the causes of adolescent pregnancy?

Dr. WYNNE. I don't know if I said those precise words. I think there are a myriad of causes, Federal Government policies are only one among many. Some of those policies I don't think are wise.

I mean, let's treat the question in that light. I think one act of unwisdom is the Federal Government's effort to promote what I call relatively uniform policies with regards to this issue.

I think the squeal rule, which we have heard discussion on earlier today, is an excellent example. Several of the witnesses were asked their opinion.

I think it is fair to say that many people are of a divided mind about the rule. That can be said with some assurance.

I would say that given that divided mind, my own opinion to the side, I think it is unsound for us to say to every State in the coun-

try must have birth control clinics to make this information available to adolescents without informing their parents.

If we are not sure about it—and I think that is one thing that we are not sure about—I think we should allow a little difference and allow some States or localities not to have such clinics rather than issuing rules or court decisions that require everybody to have it.

Then, rather than having these rather interesting but inconclusive theoretical discussions, we could let some people try it one way and some people try it another way and see what happens.

We do not know enough to come up with sure answers to these things. One of the earlier witnesses said, "If someone goes to a clinic, and they are more likely to receive contraceptive information, therefore, they are less likely to have a child." We hardly need research to demonstrate that.

The broader question, which is very hard to research, the ramifications of the Government supporting these policies. For instance, I saw in the Chicago area a student newspaper in a high school in which one of the students had gone to the clinic, She was informed her parents would not be told, et cetera, which is all the procedure, and so the student wrote a story about this and put it in the newspaper, the newspaper which is distributed free to all 2,500 students in that high school, age 13 to 17.

That is what the student paper is talking about, how to go to a birth control clinic, how to do this, your parents won't be told, et cetera, and so forth.

Now, if anyone thinks that that such articles are only read in terms of the mechanics of birth control, that is a very naive interpretation. That article is communicating a myriad of things to young people.

I think we all know it. So the question is not only about the so-called plumbing, about but also the broader things. The funding of these clinics communicate a myriad of things beyond plumbing, and we are not sure whether the sum of these effects are good or bad.

If we are not sure, we ought to allow for a little difference among the States and see what happens. So the Government's tendency to approach these things in a fairly dogmatic, nonexperimental way, I think, is very unhelpful.

Mr. BLILEY. I see. Can you comment on why inclusion of data from earlier decades in your charts is as important as you clearly think it is?

Dr. WYNNE. I think most—I can almost hold a show of hands—most of the people here, generally in this hearing room, generally know things have been going bad, but my experience with this data is most people do not realize exactly how bad things are.

I don't think most of the people in this room would say a case can be made that we are at the worst point since 1607. Now, if we know how bad we are, we may be better prepared to accept more bitter medicine.

We probably need some fairly serious changes, and part of the process of change is to know exactly what your situation is. If it is a problem that is 10 years old, you can look at it one way.

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If the problem is 30 years old, the problem has been going on for a long time, you know better in a general way the magnitude of the kinds of solutions you are going to need to be concerned with.

Mr. BLILEY. In your testimony, Dr. Wynne, you mentioned your own hypothesis concerning the underlying causes of the steady long-term increases in the rates of self- and other destructive conduct among adolescents and youth.

You mentioned your hypothesis is shared by a number of other experts. Could you tell us briefly what that hypothesis is?

Dr. WYNNE. Young people, babies, can grow up to be any kind of human beings. All of our children if reared in other environments could have grown up to be Eskimos, or Russian Communists. We all appreciate that.

If you take a baby robin and you put it in a cage and feed it, it may learn how to look for food even if it never sees another robin. Human beings unlike other animals, learn how to be human beings in particular societies by passing through certain experiences and environment.

If they don't have those, they won't learn how to be human beings appropriate to the society. The environment around our young people has been growing less and less helpful in learning how to be effective human beings.

To use the popular concept of identity, they are not acquiring a vital identity I am not saying all kids are doomed or something. There are millions of healthy kids, obviously, but the proportion of unhealthy kids is growing.

That is what the data would say. That they are not acquiring healthy enough identities. So they flail around in an experimental way trying to see where they can find a base for their emotions, their feelings, and they are not getting terribly much help.

Now, environments include a myriad of things. To take an example, one of the earlier witnesses mentioned, well, people shouldn't be preachy to young people. Well, environments partly include values.

So if we say we shouldn't preach to young people, whatever preaching is comprised of, then we are saying that any preaching to young people is a bad idea.

So then we construct an environment where you can't in any firm, clear way tell young people they should or should not do, that because that is what is connoted by preaching.

So we create an environment without clear definitions of what is good or bad.

I obviously could go on at great length in the ways the environment is changed and in some things you might do to correct it.

Mr. BLILEY. You stated in your testimony that the Federal Government or other legislative agencies can do little to explicitly regulate personal values. At the same time you say that moral values underlie many of the legislative issues which confront the Congress.

Do you think it is possible, then, for the Government policies affecting youth to be morally neutral?

Dr. WYNNE. Well, there is a story, I remember—a half digression—this guy was walking through the woods and he came upon this cabin, and then by the cabin there was a man, and there was a

bear that had come up to the cabin, so the man and the bear were wrestling.

They are fighting. The bear is trying to attack the man. So the wife is standing there. The observer turns to the wife and says, well, don't you have any feelings about this? Aren't you going to intervene? Aren't you going to take a position?

She said, "go to it, husband; go to it, bear." The Government is always taking positions and moral neutrality means you are in favor of the bear, as well as the husband.

I think to some extent that is where we are today. So we probably should be moving toward a clearer definition.

I think, again, the squeal rule, it is a very small matter. I think its causal relationship is with rising illegitimacy is perhaps 2 percent.

But the controversy over the rule is a very intellectually instructive discussion. There are surely lots of values involved there. We want parents to communicate sex to their kids.

The 13 year old goes to the high school. They read the high school paper with this article I referred it in it.

What is being communicated by that high school newspaper? I don't know. I suspect high school newspapers are legally obligated to receive ads from birth control clinics. That is my general understanding of the law.

I don't know whether there are any such birth control ads in high school papers. I would be surprised if they are not. That is more communication.

So there are differences in values among us, and they arise inevitably, and I am suggesting one of the changes for the past 20 or 30 years is we have evolved values that are not entirely helpful to young people.

Mr. BLILEY. We have heard about the confusing signals, Dr. Wynne, that families and institutions transmit to our young people. At the same time, you seem to indicate in your testimony that history shows that societies, in order to survive, need to have broadly shared values about fundamental questions.

Can you elaborate on that?

Dr. WYNNE. Well, one of the long-term changes is that the country has become more and more homogeneous, the spread of the communication media, the increase in funds from the Federal Government and from programs in general.

So we are a less diverse country than we were 30 or 40 years ago. Some of the things that are being communicated in this homogeneity are not too helpful for kids.

I wouldn't want to make television the sole whipping boy, but it is an obvious, easy example.

We need to try and reinforce what I would call more traditional modes of child/adult relations. If we have to try and do it for the whole United States of America, we are not going to get very far. It is just too hard to move.

So, again, the squeal rule is an example of such homegenization. Why can't we allow some pockets of diversity to exist within the country to try and see what other ways are more successful than others.

I think the pattern of the Supreme Court decisions, there again, have not been so helpful. Again, certain standards must be uniformly enforced.

But it appears to a lot of us, I think, that these standards are not on the whole too helpful.

Mr. BLILEY. I thank you and I thank the indulgence of the committee for our interruption for the vote. I am certain that my colleagues will have additional questions that they will want to submit for the record and submit to you.

I hope that you will respond to them as candidly as you have with me. I appreciate it.

In accord with Chairman Lehman's instructions, we are going to adjourn now and reconvene at 1:30 p.m. for our next panel.

Thank you very much.

[Whereupon, at 12:50 p.m., the task force recessed, to reconvene at 1:30 p.m., the same day.]

AFTERNOON SESSION

Mr. LEHMAN [presiding]. The meeting will reconvene of the Select Committee on Children, Youth, and Families, the Task Force on Prevention Strategies.

We have your testimony, most of your testimony in full, so you can summarize, if you please, and we will put the full testimony in the record.

The first name on the panel here is Judith Jones, will you proceed, please?

STATEMENT OF JUDITH E. JONES, ASSISTANT DIRECTOR, CENTER FOR POPULATION AND FAMILY HEALTH, COLUMBIA UNIVERSITY AT THE COLUMBIA PRESBYTERIAN MEDICAL CENTER, NEW YORK

Ms. JONES. Yes. I want to thank you, Mr. Chairman, and I want to thank the task force for inviting me to present my views concerning comprehensive pregnancy prevention services for adolescents. This is a very personal viewpoint based on the experience that I have had over the last 7 years at the Columbia Presbyterian Medical Center in New York City.

I am an assistant professor of public health and director of the Women's Health and Education Division of the Center for Population and Family Health, the Faculty of Medicine at Columbia University.

I have been involved over the past 7 years in developing and implementing a broad range of services focused on the prevention of teenage pregnancy in the Washington Heights community.

This community is representative of many urban centers across the Nation. It has shifted from a middle income, older, more stable population to a young, newly arrived, predominantly Hispanic, low-income group with serious unmet health and social needs.

The birth rate in Washington Heights has been increasing since 1973 while decreasing in Manhattan as a whole. In both 1975 and 1976, Washington Heights has had the highest birth rate of all districts in Manhattan and a rising percentage of out-of-wedlock births.

In 1976, before our prevention programs began—and I might add, I am talking about direct service prevention activities –20 percent of all of the teenage births in the city were to teenagers in Washington Heights, which had only 16 percent of the total population of Manhattan.

We like to call our programs community responsive, for in 1976 the Washington Heights Health Council had identified health problems related to teenage sexuality as a top priority for action.

However, the action and the priority couldn't go anywhere because there were no services, preventive services, for teenagers either in the hospital or in the community.

Therefore, our program priority became the rational development of direct service intervention. Family planning services have historically been provided in community-based clinics with hospitals serving solely as referral and backup resources.

Growing demand, however, coupled with the awareness of the need for more single-source, comprehensive health care has created new roles for medical centers like Columbia Presbyterian in New York City.

The challenge then, as now, is in developing programs that would truly impact on the increasing problem of early adolescent sexual activity, as well as the prevention of unwanted and unplanned pregnancy.

There were many obstacles, and I think it is important to understand that the way we developed this program was in looking at a number of the following issues.

Could a community responsive program in a major medical institution be developed that would remove barriers to access?

I am sure that you and the committee are aware that there is significant literature that says that adolescents, even knowing that family planning clinics exist, do not utilize them.

I would argue from our experience over the past 7 years that while services may be available in many communities, they are not truly accessible. I will address some of that later in my testimony.

We were, of course, concerned that the community be supportive of a program that would force adults to deal directly with the fact that adolescents were sexually active.

We were also concerned that the services be made known in an effective and appropriate manner. We were also concerned that the service be provided that would be sensitive to the cultural and social diversity of the community.

I speak specifically to that because this is a large Hispanic community. There is very little in the literature in this country at this time that would determine how best to offer these services to this group.

We feel in many ways that this may be the most important contribution we are making through our programs.

We were also concerned that we demonstrate a partnership among government, which we feel has an important role in these kinds of efforts, the community, and medical institution to provide relative and sensitive health care.

We were particularly concerned that even with the range of our programs that we could have any impact in the community. The first step in making such a program a reality was the removal of

critical barriers that prevent utilization of preventive contraceptive services by teenagers.

Parental consent requirements were removed from the hospital. Late afternoon and evening clinics were initiated to accommodate the schedules of this predominantly school-aged population.

Through the assistance of government and private sources, services were and are subsidized. The large urban hospital which would be considered less than ideal for some for these kinds of services, in fact, help to provide the anonymity and confidentiality that adolescents have identified as prime prerequisites for service utilization.

The program was and still is staffed by specially trained clinical counseling and volunteer personnel. In our particular setting the volunteer personnel primarily consists of medical students who have a formal elective within the medical school curriculum to serve as counselors in our program.

Most staff reflect the ethnic and racial diversity of the community and all are involved in ongoing training programs to strengthen their skills in dealing with the unique needs of adolescents and their relationships with others.

While I speak about adolescents as a group, we must not forget that a 13-year-old adolescent is very different than a 19-year-old adolescent and the needs for services and programs are very different in those age groups.

Furthermore, since quality health care must address, at least by our definition, the socio-emotional, as well as physical needs of our population, both group and individual counseling sessions are critical service components.

This clinic to which I am referring is called the Young Adult Clinic, and it was initiated in 1977, specifically to provide contraceptive counseling and medical assistance to adolescents 21 years of age and younger.

Now, while the clinic is the site of the medical and counseling services of our program, the major focus of this program is in and with the community. We truly believe that these kinds of programs cannot be successful, as it were, unless there is a supportive environment within the community that makes utilization of services possible and practical.

Therefore, we have worked from our very earliest days with schools, churches, parents associations, and community organizations to provide a solid foundation for our sustained efforts.

With a major emphasis on health and sex education, the community is obviously the appropriate place, we believe, to start.

We have had an intensive educational outreach program made possible by a 4-year private foundation grant that has been conducted in the schools with the support and assistance of principals, teachers, and guidance counselors.

Rather than confining our approach solely to factual material on reproductive physiology and contraception, we attempt to develop a rapport with teenagers that makes possible the discussion of the broader issues of sexuality, thereby developing their abilities to hopefully make more informed choices.

Because prevention is our goal, it became clear that these efforts had to be extended to younger age groups and, therefore, much of our work is now done in the elementary schools.

In addition to work in the schools, parent sex education seminars and conferences were begun in 1978, which now have reached literally thousands of parents in the community and throughout the city.

Also, in 1975, we developed a bilingual improvisational theater troup composed of community teenagers as a modality for increasing parent/teen communication on a number of issues, not just those relating to sexuality.

We have also worked at a household base level by developing a community health advocate program which is staffed by community residents to identify those adolescents and adolescent mothers who do not avail themselves of preventive services in a timely fashion and need personal linking to services in order to utilize them.

Currently we are developing a network of volunteer women to work in the community on a daily basis with women in need of preventive health education and referral. We are also developing educational materials that range from the importance of pregnancy prevention to the importance of early prenatal care, and they are being designed with community imput for use in "English as a second language" classes.

More important is the growing network of community organizations and individuals that have joined us as partners in these prevention efforts. Given the scope of these activities, it is obvious that we are as curious as others about what possible impacts we may have had on pregnancy prevention during this period of time.

While we cannot be absolutely sure that we are the sole cause, although that would be a tempting thing to do, the following indicators encourage us to believe that our program efforts are worthwhile.

Mr. LEHMAN. Before you start this next paragraph, excuse me, I do have to go vote. I will come back just as quick as possible.

[Recess.]

Mr. LEHMAN. If we can have time for you to finish your statement, hopefully we will have Mr. Bliley here because I have another commitment.

Ms. JONES. All right. If you would like, I can really start to abbreviate this.

I was saying that in the 5 years that we have had a pregnancy prevention direct service program at the Columbia Presbyterian Medical Center, we have had 25,000 visits, which translates to approximately 8,000 individual adolescents who, by that fact alone, speaks to a desire, we believe, of teenagers to avoid early pregnancy.

Moreover, within our specific clinic population, the percent pregnant before the first visit is down from 44 to 34 percent. This is not global data. I am talking about a specific clinical service. The percent with previous live births is down from 26 to 14 percent.

We are hopeful that these numbers signal increasing success at attracting teens in need of prevention sooner.

Finally, the data on births to teens in Washington Heights is also encouraging from our perspective. The percentage of births that were to teens in 1976 was 13.8 percent, but that number is now down to 11.9. This is in spite of a steady increase of Hispanics in

the community, which is a group with a young age composition and a relatively high birth rate.

While these data may be testimony to what can be accomplished by preventive programs, we also recognize that adolescents must be seen within the framework of their communities. We also need to join together and share our experience with others. With this in mind, the center sponsored a colloquium in 1981 with representatives of more than 50 organizations, ranging from the American Citizens Concerned for Life to the Salvation Army and many youth-serving organizations. The purpose of the meeting was to assess ways to prevent teenage pregnancy, with a particular focus on the role of families within the context of unique communities.

In bringing together representatives of diverse organizations, we did not expect uniformity of views. There are many issues about which there will always be disagreement. However, the colloquium participants shared a deep concern for the well-being of young people and reached unanimous agreement on a number of issues which are key to our discussion today.

The first of which is that prevention of adolescent pregnancy should include broad approaches that may have indirect effects. Specifically, the focus on employment counseling, job opportunities were stressed by many of the participants.

Prevention through education, as others have said today, should begin before the teenager is sexually active, which means a recognition on the part of adults to deal with the fact of earlier initiation of sexual activity by teens.

The involvement of the family can be a valuable source of support for adolescents, however no one in the group felt that parental involvement should be mandated and they also felt it was important to point out that involvement of parents, given the changes in our society, may well mean the involvement of other key adults in the young person's life, and not their specific mother and father.

Programs for parents, like those for adolescents, must be varied and flexible. In our particular case, we feel that there are issues relevant to a large Hispanic community that must be addressed that might not be relevant in other parts of the country.

What we are doing at Columbia Presbyterian, we feel is possible across the country. We do believe that the provision of service is but a first step, but we also believe that it must be expanded.

Equally important is the need to develop a cadre of trained professionals in adolescent sexuality and behavior because we feel that too many initiatives have floundered for lack of effective personnel. We also believe there must continue to be targeted public funding for services counseling and education for which there must be some methodology developed that gives programs credit for emphasizing this. The Federal Government at this point in time does not reimburse programs for counseling and education and outreach.

We also believe that we must provide continuing and specialized preventive health care services for these young people in settings that are conducive to their acceptance. At the same time, we think we must actually increase our efforts in working with adults to deal with the realities of adolescent behavior. We view teenage pregnancy as an adult problem, and not that of the adolescent. We

must continue to explore avenues that will increase parent-teen communication.

I would also, in closing, like to refer back to a statement that was made by Dr. Wynne earlier that reflected on the role of the Federal Government in these kinds of programs. I certainly agree with him that we cannot mandate what necessarily might go on in the specific community. I think the success of our programs—and I use that word deliberately—is based on the fact that our community wants our program and they want it in the way that we have developed it.

That is a very critical thing to understand. We also feel that there should be equal access to health care across this land and if we believe or define good as preventing pregnancy, and bad as not, then the Federal Government-funded clinics have been good by playing a very important role in preventing teenage pregnancy.

Thank you.

[Prepared statement of Judith Jones follows:]

PREPARED STATEMENT OF JUDITH BURNS JONES, ASSISTANT PROFESSOR OF PUBLIC HEALTH AND DIRECTOR OF THE WOMEN'S HEALTH AND EDUCATION DIVISION OF THE CENTER FOR POPULATION AND FAMILY HEALTH, FACULTY OF MEDICINE, COLUMBIA UNIVERSITY IN NEW YORK

I want to thank the task force for inviting me to present my views concerning comprehensive pregnancy prevention services for adolescents. I am an Assistant Professor of Public Health and Director of the Women's Health and Education Division of the Center for Population and Family Health, Faculty of Medicine, Columbia University in New York.

Over the past 7 years I have been involved in the development and implementation of a broad range of services focused on the prevention of teenage pregnancy in the Washington Heights community surrounding the Columbia-Presbyterian Medical Center.

This community is representative of many urban centers across the Nation. It has shifted from a middle-income, older, more stable population to a young, newly-arrived, predominantly Hispanic, low-income group with serious unmet health and social needs. The birth rate in Washington Heights has been increasing since 1973, while decreasing in Manhattan as a whole. In both 1975 and 1976, Washington Heights had the highest birth rate of all districts in Manhattan and a rising percentage of out-of-wedlock births. In 1976, before our efforts began, 20 percent of all teenage births in the city were to teenagers in Washington Heights, which had only 16 percent of the total population of Manhattan.

In that same year, the Washington Heights Council identified health problems related to teenage sexuality as a top priority for action. While there were services for teens who were already pregnant, there were no specialized services for adolescents that focused on prevention. Therefore, our program priority became the rational development of a service capable of addressing this need.

Family planning services have historically been provided in community-based clinics, with hospitals serving solely as referral and back-up resources. Growing demand, coupled with the awareness of the need for more single-source comprehensive health care, has created new roles for tertiary health care institutions like the Columbia-Presbyterian Medical Center. The challenge to us was developing a program that would truly impact on the increasing problem of early adolescent sexual activity as well as the prevention of unwanted and unplanned pregnancy.

The possible obstacles were many: Could a community-responsive program in a major medical institution be developed that would remove barriers to access? Would the community be supportive of a program that would deal directly with adolescent sexual activity? Could the availability of services be made known in an effective and appropriate manner? Could a service be provided that would be sensitive to the community's social and cultural diversity? Could we make a partnership among government, the community and a medical institution to provide relevant and sensitive health care? And would the range of programs have any impact on the problem?

The first step in making such a program a reality was the removal of the critical barriers that prevent utilization of these services by teenagers. Parental consent re-

quirements were removed. Late afternoon and evening clinics were initiated to accommodate the schedules of this predominantly school-age population. Through the assistance of government and private sources, services were subsidized. The large urban hospital, which would be considered less than ideal by some, in fact helped to provide the anonymity and confidentiality that adolescents have identified as a prime prerequisite for service utilization. The program was (and still is) staffed by specially trained clinical,[1] counseling and volunteer personnel who have a genuine desire to work with young people. Most reflect the ethnic and racial diversity of the community, and all are involved in ongoing training programs to strengthen their skills in dealing with the unique needs of adolescents and their relationships with their families. Furthermore, since quality health care must address both socio-emotional and physical needs, both group and individual counseling sessions are critical service components.

Thus in the fall of 1977 a Young Adult Clinic, incorporating these features, was opened to provide contraceptive counseling and medical assistance to adolescents 21 years of age and younger. While the clinic is the site of these medical and counseling services, the program's focus and many of its activities are in and with the community. We believe that it is only through working with schools, churches, parents' associations and community organizations that a solid foundation for a sustained effort can be achieved. With the major emphasis on preventive health and sex education, where better to begin but in the community in which these adolescents live? An intensive educational outreach program, made possible by a 4-year private foundation grant, has been conducted in the schools, with the support and assistance of principals, teachers and guidance counselors. Rather than confining our approach solely to factual material on reproductive physiology and contraception, we attempt to develop a rapport with teenagers that makes possible the discussion of broader issues of sexuality, thereby developing their abilities to make choices. Because prevention is our goal, it became clear that these efforts had to be extended to younger age groups. Therefore, much emphasis has been placed on developing pertinent programs for non-sexually active pre-teens as well.

In addition to work in the schools parent sex education seminars and conferences were begun in 1978 which have now reached thousands of parents in the community and throughout the city. Also in 1975, a bilingual improvisational theater troupe, composed of community teenagers, was developed as a modality for increasing parent-teen communication. Working at a household-based level, a community health advocate program, staffed by community residents, identified large numbers of adolescents in need of preventive services and educational counseling, and referral services were provided.

Currently, a network of volunteer community women is being developed to provide ongoing preventive health education referral for community residents. Educational materials that range from the importance of pregnancy prevention to the importance of early prenatal care are also being designed with the community for use in English as Second Language classes. More important is the growing network of community organizations and individuals that have joined us as partners in these efforts.

Given the scope of our activities, what impact have we had in this period of time? While we cannot be absolutely sure that we are the sole cause, the following indicators encourage us to believe that our program efforts are worthwhile:

We have had over 25,000 visits by approximately 8,000 individual teenagers in the 5 years of clinical services. Surely this volume speaks to a desire by teenagers to avoid early pregnancy. Moreover, within our clinic population, the percent pregnant before the first visit is down from 44 to 34 percent. The percent with previous live births is down from 26 to 14 percent. We are hopeful that these numbers signal increasing success at attracting teens in need of prevention sooner. Finally the data on births to teens in Washington Heights is also encouraging. The percentage of births that were to teens in 1976 was 13.8 percent, but that number is now down to 11.9 percent. This is in spite of the steady increase of Hispanics in the neighborhood, a group with a young age composition and a comparatively high birth rate.

While these data may be testimony to what can be accomplished by preventive programs, we must recognize that adolescent pregnancy, like many other societal problems, is an expression of a multitude of social, economic and emotional forces. Thus if we are to deal with adolescents as complete individuals, we must share our experience and coordinate our efforts.

With this in mind, the Center sponsored a colloquium in 1981 with representatives of more than 50 organizations, ranging from the American Citizens Concerned

[1] Physician, nurse-midwives, nurse-practitioners.

for Life to the Salvation Army and many youth-serving organizations. The purpose of the meeting was to assess ways to prevent teenage pregnancy, with a particular focus on the role of families within the contexts of unique communities.

In bringing together representatives of diverse organizations we did not expect uniformity of views. There are many issues about which there will always be disagreement. However, the colloquium participants shared a deep concern for the wellbeing of young people, and reached unanimous agreement on a number of issues key to our discussion today:

1. Prevention of adolescent pregnancy should include broad approaches that may have indirect effects. Such broad approaches as employment counseling and job training for adolescents, discussion groups aimed at setting personal goals and values clarification might help teenagers in making decisions about sexuality and childbearing. These should be combined with services related directly to sexuality and contraception.

2. Prevention through education needs to begin before the teenager is sexually active.

3. The involvement of the family can be a valuable source of support for adolescents, but family involvement does not necessarily mean the involvement of parents, since a large proportion of teenagers do not live in the traditional nuclear family.

4. Programs for parents, like those for adolescents, must be varied and flexible. No single program design will work in all situations or meet the needs of all families. We need to find out which designs work best in a given setting, or for a particular target group.

What we are doing at the Columbia-Presbyterian Medical Center is possible across this country. The provision of service is but a first step and must be expanded. Equally important is the need to develop a cadre of trained professionals in adolescent sexuality and behavior, for too many initiatives have floundered for lack of effective personnel. Moreover, targeted funding for services, counseling, and education has to be available to ensure that this group will continue to receive the kind of special attention and support that will make the critical difference. We must provide continuing and specialized preventive health care services for these young people in settings that are conducive to their acceptance. At the same time, we must work with adults to assist them in dealing with the realities of adolescent behavior. And we must continue to explore avenues to increase parent-teen communication.

The challenge we face, on a national and local level, is to improve the quality of and access to services in a manner that will focus on preventive rather than therapeutic care, and to develop comprehensive programs that are community-responsive and culturally relevant.

Mr. LEHMAN. Thank you.

We have a little manpower problem. I am chairman of the Appropriations Subcommittee on Transportation and we have to convene in a few minutes. I was hoping Mr. Bliley—have you been able to reach him?

So what I will do is I will recess for a few minutes so Mr. Bliley can come here and then he can hear the last two witnesses. I will have to go to my other meeting. If he does not show up, I will come back and adjourn the meeting and then you can file your statements for the record. He is on his way over here, from what I understand from his staff. So if you will be patient, we will recess the meeting for a few minutes. If he does not come back, I will come back.

Did you reach Mr. Bliley? We will find him and we will get him here. If he cannot, they will know where to reach me and I will come back.

I want to thank you for being here. Just be patient for a few minutes.

[Recess.]

Mr. BLILEY [presiding]. My apologies. It is not always this bad; and then again, sometimes it is worse.

You will have to bring me up to speed. Where are we? Have you had your testimony?

Ms. JONES. Yes, I have.

Mr. BLILEY. OK. Have the others?

Why do we not finish with the testimony and then we will move to the questions.

Dr. Weir.

STATEMENT OF MAURICE WEIR, PROJECT DIRECTOR, CITIES-IN-SCHOOLS, INC., WASHINGTON, D.C.

Mr. WEIR. Yes, sir. I would like to thank the members of the select committee and to immediately make a correction in the addressing to myself as "Doctor" in the agenda, as I am not a doctor of any sorts. I was told that I might be able to have one conferred by one of the staff here and I would gladly accept it, but until that happens, I will have to make that correction.

In addition, I would like to offer, before I start into my testimony, a bit of an apology for this being a document typed by my own hand and therefore carrying all the flaws of my limited typing ability.

I am the director of the Cities-in-Schools adolescent health center's adolescent pregnancy program. Cities-in-Schools is a private, nonprofit organization whose founders and current staff have, for 20 years, been developing and refining program models to effectively serve children, youth and families.

Cities-in-Schools strives to effectively integrate existing medical, educational, and social services by coordinating the delivery of existing services and using a school or single site through which these services are distributed.

CIS maximizes the impact of the service delivery system on the target population while minimizing administrative overhead and establishing an active communication network among service providers.

CIS is currently facilitating programs in eight cities throughout the country. In each of these cities, we are working very closely with local government and school officials and numerous public and private agency heads in developing and refining coordinated delivery systems using existing services.

Today, I would like to share with you the Cities-in-Schools' perspective on coordinating services and how this concept is being successfully implemented in the CIS adolescent pregnancy program in Washington, D.C.

We no longer live in an agrarian society where social needs are met simply. Life on a farm or a small village once allowed many human problems to be met by doses of good will and cooperation. Needs were visible and solutions were more a matter of commitment than anything else.

However, with the rapid growth of an industrial society, the responsibility for meeting the social needs have been transferred from the extended family and volunteer groups to large public institutions.

Institutions influence our lives daily. It is the inevitable price of technology. Public institutions especially dominate the lives of the

poor. Welfare, legal aid societies, clinics, housing projects, and food stamp programs control the poor with abject finality.

Public institutions make valiant attempts to serve clients, but all too often their urban strategies are woefully inadequate. Children are hit hardest by this problem. A child with financial, legal, emotional, or health problems will have difficulty concentrating on schoolwork. In today's technological society, school is essential to success. Yet, in some of our major urban areas, almost half of our young people are dropping out before graduation.

How has the most business potent society in history failed to excel in the business of serving the poor, or helping the unproductive become productive?

I will leave that question unanswered for the moment.

Cities-in-Schools believes that the resources to help young people are in large part already allocated. According to studies done by Cities-in-Schools in 1974 through 1977, the ratio of full-time paid professionals to the youth they serve in targeted areas was approximately 1 to 7. Even with recent budget cuts, we still suggest the ratio is 1 to 10. However, because they lack proper structure, big city health and human service administrations are fragmented systems, ofter characterized by lack of coordination. In effect, each insitution develops its own service policy without awareness of the policies of other institutions and without awareness of the client's other service needs.

Lack of outreach: Clients must go in different directions for different services. Often they must travel long distances to reach services.

Lack of personalism: Each client deals with many providers. Providers have large caseloads. No personal relationships are developed.

Lack of accountability: Providers and clients are rarely held accountable for failure or rewarded for successful impact on individual lives.

Low productivity: Morale of providers is low and burnout is frequent. For many clients, the barriers are sufficient to prevent them from seeking help.

In response to these problems, Cities-in-Schools has clarified a set of principles which we think should guide the development of all human service programs in order to make best use of existing resources.

With funding from the Department of Health and Human Services, Office of Adolescent Pregnancy programs, we have been able to establish a demonstration project targeting services to pregnant and parenting teenagers in Washington, D.C., using these principles:

First, focus the services at a central, easily accessible location. The program is housed in a facility located in the 14th Street corridor of ward 1 and is easily accessible to public transportation.

All of the following services are offered at this single site: Health-related services which include pregnancy testing, family planning counseling, pre- and postnatal care, childbirth education, nutrition counseling, VD screening, pediatric care, dental screening, mental health services, and basic education classes, family life education, GED preparation, vocational training, consumer educa-

tion, parenting classes, adoption counseling, day care, social service counseling and assistance, transporation, recreation, and spiritual guidance and counseling.

Second, use existing staff and resources from existing institutions, whenever possible, to avoid the need for massive injections of new funding and duplication of services.

More than 25 agencies have affiliated with the program to coordinate existing services. Examples include:

A private agency has donated the 48,000-square-foot facility which houses the program rent free;

The D.C. Commission on Public Health details medical staff to the program;

A private agency details mental health staff to the program;

The D.C. Department of Human Services provides free administrative consultation;

District of Columbia public schools provides books and teaching aids to the project. Clients enrolled in our educational component can receive Carnegie unit credit at their home school and thus avoid dropping out;

Two hospitals, one private, one public, provide backup to our clinic. Clinic physicians and midwives have been awarded privileges at each hospital. Hospital physicians back up the midwives. Long-term pediatric followup is conducted by the hospitals in coordination with the program. Both hospitals have agreed to provide services to all program clients, regardless of their ability to pay;

Two nondenominational christian organizations provide staff who offer voluntary counseling on-site to clients and their families;

The local YMCA details staff to provide recreational and cultural enrichment activities onsite.

I should mention here that the building that we got for the program had an added benefit of a pool and a gym and we were able to negotiate with the local Y to provide the staff to operate that. It was an added feature and attraction, both for males and females, to the program.

A private agency provides details staff to tutor students in the educational component;

Another private hospital has agreed to detail staff to the program who will assume responsibility for family planning services; and

A local university shares in the cost of a detailed staff person who conducts the program evaluation.

All of the affiliated agencies have a direct interest in pregnant and parenting teenagers. The personnel released from traditional service formations to work at the project site continue to be employed by, and accountable to, their home agencies, but they go to work at the program site where their clients are.

Third, structure the program so that each client has an opportunity to experience a one-on-one, supportive relationship with a service provider. Each staff person at the project is assigned a case load of approximately 20 clients and their families. This staff person becomes the primary link with the resources of the delivery system, plus advisory, referee and confidant.

Client progress and staff productivity are closely monitored through the case load structure.

Fourth, we suggest that you emphasize small, easily manageable delivery units of multidisciplined staff so that providers can coordinate their talents and resources to meet the needs of each client holistically.

Fifth, incorporate a sophisticated evaluation and monitoring system so that accountability is clearly defined and closely monitored by all areas of service.

The Howard University Urban Studies Institute has accept responsibility for evaluation and monitoring. Data is collected on every client on service needs, services delivered, outcomes, et cetera. Data is then compiled for each program component.

The information is used in making program modifications, assessing service delivery efforts and to report to participating agencies on the relative impact of their involvement.

Sixth, build partnerships between public and private sectors and between the different levels of government for funding and governance of the program. Cities In Schools [CIS] has organized a local advisory board made up of representatives from the city government, the school system, the business community, State government, participating service agencies, and the families being served. CIS works with this group to solicit and focus existing resources, ideas and people at the project site.

I will pause here briefly and go back to the question that I raised earlier in regard to why we have not, being the most potent business societies in the world, been more successful in addressing the business of the poor. I come back to No. 6 here because I think it is a key to one of the things that the Federal Government needs to be looking at, not only down to how it might coordinate vertically with State and city governments and other agencies, but horizontally within departments and across department lines.

We have found that all too often, even at the Federal level, policy issues are decided upon separately and not in conjunction with the thinking of departments who also impact on that same issue. This provides confusion; it provides a great deal of frustration to those at the lower levels who have to respond to, by way of proposal or by way of communication, to those varying policies that could better serve all concerned if they were planned in conjunction and coordination.

At the same time, a very strong effort to solicit the involvement of the private sector and other agencies, not merely from the standpoint of hearings and advice, but from the standpoint of actual planning and sharing of the factors that are being considered most weightedly in Federal policy decision, should be allowed for groups that are going to eventually be affected by either using Federal funds or having to work with groups that have it.

So we suggest here, also, that from a management and organizational structure point of view, the Federal Government needs to reach out in a different kind of way to the other service providers at all levels of the public and private sectors.

The CIS adolescent pregnancy program is successfully demonstrating that working partnerships among groups whose efforts are typically uncoordinated can have a positive impact. This impact is seen, not only in the lives of individual pregnant and parenting

teens, but also in the development of new ways of thinking within the agencies that the program has touched.

The success of the program to date is reflected in the award for "outstanding services and contributions to the Department of Human Service and the citizens of the District of Columbia in the areas of adolescent pregnancy prevention, medical, educational, and social services to pregnant adolescents; improved birth weights of babies of adolescent mothers; and reducing repeat pregnancies," which was issued to Cities In Schools by the Department of Human Services at its 1982 award ceremony.

I should point out that I believe that is carefully worded and each of those areas that they cite, the low birth weights and so on, were, in fact, the true outcomes and impact on the program inside of its first year of operation. Accepting that award, and going back to the note where I pointed out that the number of agencies involved, we could not but accept with the understanding that it was an award that had to be shared by all those who were involved.

Thank you.

Mr. BLILEY. Thank you very much, Mr. Weir.

[Prepared statement of Maurice E. Weir, Sr., follows:]

PREPARED STATEMENT OF MAURICE E. WEIR, SR., DIRECTOR, CITIES IN SCHOOLS, ADOLESCENT HEALTH CENTER, ADOLESCENT PREGNANCY PROGRAM

Mr. Chairman and Members of the Select Committee's Task Force:

I would like to begin by first correcting the mistaken reference to me, as Doctor, in the agenda. I am neither an M.D. or Ph. D. I am the Director of the Cities In Schools, Adolescent Health Center's, Adolescent Pregnancy Program. Cities In Schools Inc. is a private, non-profit organization whose founder and current staff have, for 20 years, been developing and refining program models to effectively serve children, youth and families. Cities In Schools strives to effectively intergrate existing medical, educational and social services. By coordinating the delivery of existing services and using a school or single site through which these services are distributed, CIS maximizes the impact of the service delivery system on the target population, while minimizing administrative overhead and establishes an active communication network among service providers. CIS is currently facilitating programs in eight cities throughout the country. In each of these cities we are working very closely with local government and school officials, and numerous public and private agency heads in developing and refining coordinated delivery systems using existing services.

Today I would like to share, with you, the Cities In Schools perspective on coordinating services and how this concept is being successfully implemented in the CIS Adolescent Pregnancy Program in Washington, D.C.

We no longer live in an agrarian society where social needs are met simply. Life on a farm or in a small village once allowed many human problems to be met by doses of good will and cooperation. Needs were visible and solutions were more of commitment than anything else. However, with the rapid growth of an industrial society, the responsibility for meeting the social needs has been transferred from the extended family and volunteer groups to large public institutions.

Institutions influence our lives daily. It is the inevitable price of technology. Public institutions especially dominate the lives of the poor. Welfare, legal aid societies, clinics, housing projects and food stamp programs control the poor with abject finality.

Public institutions make valiant efforts to serve clients, but all too often their urban strategies are woefully inadequate. Children are hit hardest by this problem. A child with financial, legal, emotional or health problems will have difficulty concentrating on school work. In today's technological society, school is essential to success. Yet, in some of our major urban areas, almost half of our young people are dropping out before graduation.

How has the most business potent society in history failed to excel in the business of serving the poor . . . of helping the unproductive become productive?

Cities In Schools believes that the resources to help young people are in large part already allocated. According to studies done by Cities In Schools in 1974-1977, the ratio of full-time paid professionals to the youth they served in targeted areas was approximately 1.7. Even with recent budget cuts, we still suggest the ratio is 1.10. However, because they lack proper structure, big city health and human service administration are fragmented systems, often characterized by: Lack of Coordination—each institution develops it's own service policy without awareness of the policies of other institutions, and without awareness of the client's other service needs, Lack of Outreach—Client's must go in different directions for different services. Often they must travel long distances to reach services, Lack of Personalism—Each client deals with many providers. Providers have large caseloads. No personal relationships are developed. Lack of Accountability—providers and client's are rarely held accountable for failure or reward for successful impact on individual lives. Low Productivity—morale of providers is low and burnout is frequent. For many clients, the barriers are sufficient to prevent them from seeking help.

In response to these problems, Cities In Schools has clarified a set of principles which we think should guide the development of all human service programs in order to make best use of existing resources. With funding from the Department of Health and Human Services, Office of Adolescent Pregnancy Programs, we have been able to establish a demonstration project targeting services to pregnant and parenting teenagers in Washington, D.C. using these principles: (1) Focus the services at a central, easily accessible location. The program is housed in a facility located in the 14th Street corridor of Ward I and is easily accessible to public transportation. All of the following services are offered at this single site: Health Related-Pregnancy testing, family planning counseling, pre and post-natal care, childbirth education, nutrition counseling, VD screening, pediatric care, dental screening, mental health services; basic education classes, family life education, GED preparation, vocational training, consumer education, parenting classes, adoption counseling, day care, social service counseling and assistance, transportation, recreation, and spiritual guidance and counseling. (2) Use existing staff institutions whenever possible to avoid the need for massive injections of new funding and duplication of services. More than twenty five agencies have affiliated with the program to coordinate existing services. Examples include:

A private agency has donated the 48,000 sq. ft. facility, which houses the program rent free.

The D.C. Commission on Public Health; details medical staff to the program.

A private agency details Mental Health staff to the program.

The D.C. Department of Human Services provides free administrative consultation.

D.C. Public Schools provides books and teaching aids to the project. Clients enrolled in our educational component can receive carnegie unit credit at their home schools and thus avoid dropping out.

Two hospitals, one private/one public provide back up to our clinic. Clinic physicians and midwives have been awarded privileges at each hospital. Hospital physicians back up midwives. Long term pediataric follow-up is conducted by hospitals in coordination with the program. Both hospitals agreed to provide services to all program clients regardless of ability to pay.

Two non-denominational Christian organizations provide staff who offer voluntary counseling on site to clients and their families.

The local YMCA details staff to provide recreational and cultural enrichment activities on site.

A private agency provides detailed staff to tutor students in the educational component.

Another private hospital has agreed to detail staff, to the program, who will assume responsibility for family planning services.

A local university shares in the cost of a detailed staff person who conducts the programs evaluation.

All of the affiliated agencies have a direct interest in pregnant and parenting teenagers. The personnel released from traditional service formations to work at the project site continue to be employed by and accountable to their home agencies, but they go to work at the program site where the clients are. (3) *Structure the program so that each client has an opportunity to experience a one-on-one, supportive relationship with a service provider.* Each staff person at the project is assigned a *CASE-LOAD* of approximately twenty (20) clients and their families. This staff person becomes the primary link with the resources of the delivery system, plus advisor, referee, and confidant. Client progress and staff productivity are closely monitored through the caseload structure. (A) *Emphasize small, easily manageable delivery*

units of multidisciplined staff so that providers can coordinate their talents and resources to meet the needs of each client holistically. (5) *Incorporate a sophisticated evaluation and monitoring system so that accountability is clearly defined and closely monitored by all areas of service.* The Howard University Urban Studies Institute has accepted responsibility for evaluation and monitoring. Data is collected on every client on service needs, services delivered, outcomes, etc. Data is then compiled for each program component. The information is used in making program modifications, assessing service delivery efforts and to report to participating agencies on the relative impact of their involvement. (6) *Build partnerships between public and private sectors, and between the different levels of government, for funding and governance of the program.* CITIES IN SCHOOLS has organized a local *ADVISORY BOARD* made up representatives from city government, the school system, the business community, state government, participating service agencies, and the families being served. CIS works with this group to solicit and focus existing resources, ideas and people at the project site.

The CIS Adolescent Pregnancy Program is successfully demonstrating that working partnerships among groups whose efforts are typically uncoordinated can have a positive impact. This impact is seen, not only in the lives of individual pregnant and parenting teens, but also in the development of new ways of thinking within the agencies the program has touched.

The success of the program to date is reflected in the Award for "Outstanding services and contributions to the Department of Human Service and the citizens of the District of Columbia in the areas of adolescent pregnancy prevention; medical, educational and social services to pregnant adolescents; improved birthweights of babies of adolescent mothers; and reducing repeat pregnancies," which was issued to CITIES IN SCHOOLS by the Department of Human Services at its 1982 Award Ceremony.

Mr. BLILEY. Mrs. Driscoll.

Also, while you are getting ready, I would like to extend to you the apologies of your Congressman, George Miller, who would be here except for his presence being required on the floor.

STATEMENT OF PAT DRISCOLL, DIRECTOR, WOMANITY, WALNUT CREEK, CALIF.

Mrs. DRISCOLL. Thank you very much, Mr. Bliley.

I do want to thank you for the opportunity to testify as a citizen and a taxpayer and a concerned parent on the vital issue of adolescent pregnancy prevention.

I am here to try to convince you to bring the full power of the Federal Government to promote a foolproof method of reducing teen pregnancy, specifically abstinence. By this, I do not mean to imply that another bureaucracy should be established, but rather, I am proposing that out of existing Federal funding levels, a higher priority should be given to programs promoting abstinence.

I would like to show the irrationality of the present government policy by contrasting how we deal with two teen problems, teen shoplifting and teen sex:

Teen shoplifting is a growing social problem, but we certainly do not fund programs to promote responsible shoplifting so that those who choose to shoplift can learn how to do so without getting caught.

But we are doing just that with the teen sex problem. Government-funded programs, such as the Office of Family Planning and Planned Parenthood, claim to be promoting responsible sex by teaching contraception and abortion. They teach our teens how to have sex but not get caught.

And the result? The youth are getting caught. The teen sex problem is worse than ever.

In an editorial of Family Planning Perspectives—September and October 1980—Zelnik & Kantner show that more teenagers are using contraceptives and using them more meticulously than ever before. Yet the number of premarital pregnancies continues to rise.

At this point, I would like to request that the referenced article by Dr. Ford, which is in Heartbeat Magazine, be inserted into this testimony.

Mr. BLILEY. Without objection, it will be.

Mrs. DRISCOLL. Thank you.

[The information follows:]

TEENAGE PREGNANCY, CONTRACEPTION AND ABORTION: AN ANALYSIS OF CHANGING TRENDS

(By James H. Ford, M.D.)

(The following is excerpted from a talk given by Dr. James H. Ford at the Tenth Annual AAI Academy in Phoenix, Arizona, November 1981.)

Of the one-and-one-half-million abortions performed annually in the United States, about one-third of them are performed on teenagers—most of them unmarried teenagers. Just the moral implications of this fact alone are overwhelming! But the social implications are also important, and in fact, quite far-reaching, because of the other social phenomena with which such massive teenage abortion is connected.

The close connection between the rising rates of teenage abortion, promiscuity, premarital pregnancy, and illegitimacy seem obvious enough. But the connection between rising teenage abortioin rates and the inversely proportionate, falling rates of marriage and family-formation among teenage girls has probably been less obvious. Nevertheless, such a connection has now been well demonstrated also.

The relationship between abortion, pregnancy and sexuality, surely is obvious enough. Before any woman can have an actual abortion, she has to be pregnant. And before she can be pregnant (barring some form of artificial insemination), she has to have sexual intercourse. And before this can occur, it is essential that a willing and able man be readily available to her.

In this context, even the merest glance at the latest rhetoric of so-called "pro-choice" spokesmen can leave little doubt that the campaign to keep abortion-on-demand legalized, is just another aspect of the campaign to promote and extend the sexual revolution.

ABORTION AND THE CONTRACEPTIVE REVOLUTION

Abortion, as a public policy and as a matter of widespread practice, does not exist in a moral vacuum; and this phenomenon cannot be adequately appreciated in isolation from such issues as the so-called "sexual revolution" which has so much captured the imagination of so many of our young people. The sexual revolution, in turn, cannot be understood in isolation from the contraceptive revolution of which it is an inherent part.

The abortion mentality and the contraceptive mentality flow from the same philosophical underpinnings. Even a most superficial inquiry into the thought-processes of leading abortion advocates will reveal this assertion to be a self-evident truism. Abortion is seen by many as just another part of birth control technology.

Dr. Charles Westoff is a professor of sociology at Princeton University, a leading spokesman for the Planned Parenthood cause, and a member of the science advisory panel of the Alan Guttmacher Institute (which is the research arm of the Planned Parenthood Federation of America). Dr. Westoff tells us that such trends as childless marriages, the separating of sex from reproduction, and the weakening of the permanence of marriage are closely connected to such factors as the development of birth control technology, the rise of militant feminism, and the diminishing influence of religion in our lives. He suggests that these trends confirm his belief that we are fast approaching the perfect contraceptive society.

It behooves us all, then, not to underestimate the significance of these trends and their harmful effects on the future of the traditional family.

ABSTINENCE HAS BEEN THE NORM IN MOST CULTURES UNTIL RECENTLY

Historically, most cultures have attempted to control adolescent sexual activity. Most industrialized countries have traditionally prohibited premarital sex among

adolescents. In many countries, total abstinence from intercourse has been the standard of behavior expected of unmarried adolescents.

But now we are given much evidence that the incidence of adolescent sexual activity at an earlier age is increasing in the United States—in fact, more so in the U.S. than in many other countries.

In 1978, the U.S. Commission on Population, conservatively estimated that 1.5 percent of all 13 and 14 years olds in this country had had intercourse. That's a dramatic eightfold increase since Kinsey's day, in the number of teenagers having such earlier sexual experience.

THE MORAL CLIMATE AND THE ROLE OF THE FAMILY

A much more important and little mentioned factor in this trend is the changing moral climate, and the changing role of the family, in the lives of so many teenagers. The family's role—or lack of it—seems most crucial.

Kantner and Zelnik (professors of demography at Johns Hopkins University) found that teenage girls living in fatherless families were 60 percent more likely to have had intercourse than those in two-parent homes. And girls who said that they confided in their parents were substantially less likely to have had premarital intercourse than those with little parental communication.

SIMPLISTIC, ONE-DIMENSIONAL THINKING

It is unfortunate that the public concern about teenage sexuality in the past few years has come to be focused almost exclusively on the problem of rising teenage illegitimacy. Much of this attention is the result of frequent agitations on the subject within the public mind, by various birth control groups. Indeed, among some groups, the only concern about adolescent sexuality has come to be its implications with respect to pregnancy, and the alleged overpopulation problem.

In fact, population groups such as Planned Parenthood continue to engage in simplistic, one-dimensional thinking that says that pregnancy is the only problem, and that contraception is the only solution.

As a consequence, contraceptive usage has become a commonly recommended substitute for our society's traditional encouragement of premarital abstinence.

In this context, it is of considerable significance and worth noting here, and I say this rather pointedly—that the overriding concern of these so-called "family planning" programs for teenagers (just as it is for adults) has actually been shown to be population control, not illegitimacy!

THE FAILURE OF THE CONTRACEPTIVE APPROACH

Over the five-year period between 1971 and 1976, during which Planned Parenthood quadrupled its birth control services to teenagers, the incidence of premarital intercourse among white teenage girls increased 41 percent, and there was a 45 percent increase in the proportion of 15 to 19 year-old white girls who experienced at least one premarital pregnancy during that same period. That would appear to be a terrible admission of failure for the contraceptive approach.

But instead of such a frank and honest admission of failure for the contraceptive approach (or some explanation for such failure), Planned Parenthood spokesmen have attempted to confuse the matters and to evade this conclusion, which is so damaging to the thesis they had set out to prove.

Furthermore, it seems apparent from the available evidence that by encouraging abandonment of chastity as a means of avoiding pregnancy, Planned Parenthood and its allies have served their own purposes quite well by creating a larger new teenage clientele for their abortion and contraceptive services. For this, if for no other reason, the purity of their motives must be considered suspect.

EFFORTS TO EXPLAIN AWAY THE DIFFICULTIES

Basically, Planned Parenthood people continue to explain away the increase in premarital pregnancy by suggesting that this problem occurs mostly in girls who do not have access to contraceptive services. They still insist that this problem can be solved simply by further applications of the same old solution.

The fact that these birth control groups have been applying this same old solution for over ten years, without coming close to their stated objective, should, presumably, be sufficient to demonstrate to the most rigorous skeptic that the practicability of the contraceptive approach, in the case of teenagers, is open to serious question. But apparently, Planned Parenthood people still can't see this. In fact, they recently

referred to their teenage birth control program as a great "success" story (Family Planning Perspectives, May/June '81, P. 108).

It is important to realize that many pre-marital pregnancies are intentional, and that this category of pregnancy cannot be prevented by any kind of contraceptive program. In their study, Zelnik and Kantner found that intentional pregnancies account for about 20 to 25 percent of all teenage pregnancies.

But another recent study found (among one group of pregnant teenagers) that more than 60 percent of them had become pregnant deliberately. (Ryan and Sweeny, Obstet Gynecol, June '80).

It should also be noted (if we limit our consideration only to unintended premarital pregnancies) that as many as 13.4 percent of those reported in the 1971 survey had occurred even in situations, and at times, when a contraceptive *was* being used. By 1976, this proportion had risen to 18.8 percent.

Among white teenagers, who showed the greatest improvement in contraceptive use during this period, the increase in the proportion of all unintended premarital pregnancies was even more marked, rising from 13.3 percent 1971 to 23.5 percent in 1976.

Meanwhile, those teenage girls who relied on *abstinence* as a pregnancy-prevention method, continued to maintain a perfect zero-percentage rate!

Zelnik and Kantner show that more teenagers are using contraceptives, and using them more meticulously than ever before. Yet the number of premarital pregnancies continues to rise. (*Family Planning Perspectives*, Editorial, Sept/Oct '80).

To further complicate and darken this dismal picture, we note that there has been a continued decline in the number of pregnant teenagers who marry in the course of their first pregnancy. The increasing availability of abortion in the past decade has undoubtedly played an important part in this trend.

In fact, there is a close reciprocal relationship between increasing abortion and declining marriage. Zelnik and Kantner found that in 1979, among white teenage girls who were unmarried at the time their pregnancy was resolved, 45 percent of them chose to have an abortion. Conversely, and significantly, none of the teenage girls who married before the resolution of their first pregnancy reported having had an abortion. Similarly, and of equal significance, Zelnik and Kantner found it unlikely that very many teenagers who are already married would want to terminate a pregnancy by abortion.

It follows then that, for many women, their attitude toward pregnancy and motherhood is strongly dependent on the man's attitude. If the putative father accepts the idea of marriage in the presence of a premarital pregnancy, he tacitly accepts the idea of motherhood also, and usually, so does the woman. On the other hand, if the man rejects the idea of marriage and motherhood, the woman often seeks an abortion.

Regarding the decision to seek an abortion then; it appears that, quite often, the main factor influencing the woman is a selfish, rejecting, or anti-motherhood attitude learned from the man.

EASY ABORTION ENCOURAGES MALE IRRESPONSIBILITY

It also seems obvious that many men are less willing, in recent years, to marry the woman they have made pregnant, because of their increasing awareness that abortion is readily accessible to the woman, should she choose to avail herself of such a "quick-fix solution."

But, in fact, the man's refusal to marry the woman is, itself, often a crucial factor in her decision to seek an abortion; because she is then placed in an emotional bind by having to choose, out of desperation, between either the perceived shame and desolation of an out-of-wedlock birth, or the hope of a quick-and-easy, secret escape, held out by the readily available abortionist.

Easy abortion, therefore, encourages more male irresponsibility, and increased male irresponsibility, in turn, encourages greater recourse to abortion on the part of women.

ABORTION: MALE-FEMALE ANTAGONISMS

For many years now, an oft-repeated slander against pro-life partisans has regularly emanated from the pro-abortion camp, to the effect that we who oppose abortion do so only because we look down on women, and that we see childbirth as some sort of vindictive punishment to be inflicted upon them.

This dastardly calumny was again repeated by Dr. Irvin Cushner, a pro-abortion professor from U.C.L.A., at a pro-abortion rally in Los Angeles. As Dr. Cushner put it "Anybody that says the right of an unborn fetus is greater than the right of

choice of a grown female, must have, at the very minimum, a great disrespect and disregard for women."

But nothing could be further from the truth. Besides being slanderous, Dr. Crushner's accusation also distracts us from the basic fact that all the polls I've ever seen show that more men than women favor easy abortion, because, presumably, easy-abortion very well serves the selfish interests of men.

The truth of this assertion was well demonstrated by a revealing admission by a pro-abortion attorney at the very same pro-abortion rally.

Eddie Tabesh, speaking on behalf of the California Abortion Rights Action League, said that, "Every man should realize that if abortion is outlawed, there are going to be a lot more paternity suits, and a lot more cold showers." (L. A. Herold Examiner, 10/18/81).

It seems evident then, that easy abortion makes the sexual exploitation of women easier for pro-abortion men.

PRO-LIFE CONCERNS ARE POSITIVE

Our concern, as pro-life people, is something positive—it is a desire to protect the life of all innocent human beings (especially those who are in need of protection)—including unborn children.

The fact that we are emphasizing a concern to protect unborn children so much more in recent years (because they are currently under such massive attack) does not mean that we care less about the associated suffering of women in their role as mothers—nor are we insensitive to such suffering.

ILLEGITIMACY HAS INCREASED

Because of the increased recourse to abortion, there are, proportionally, fewer live births. At the moment, abortion remains the major means by which young women are preventing births they do not wish to have.

But the increased use of abortion has not kept pace with the decline in the willingness of the young men involved, to marry the girls whom they have, so thoughtlessly, made pregnant. The net result of all this has been a rise in the proportion of all pregnancies ending in out-of-wedlock births, and an increase of illegitimacy, at least among sexually active, white teenagers. As a result, the problem of illegitimacy among teenage girls, which Planned Parenthood supposedly set out to reduce, has become progressively worse, and has more-or-less paralleled the rise in teenage abortions (abortion rates increased about 50 percent, and out-of-wedlock birth rates increased about 2.5 percent, over an eight-year period).

It is for this reason that some of us almost choke when we hear Planned Parenthood falsely putting forth their so-called "services" as somehow, being something of special benefit to the public, or as being especially deserving of the moral and financial support of the community—allegedly, because these programs reduce the incidence of teenage pregnancy. These claims are not only not true in actual practice; they are contradicted, even in theory, by studies which should be well-known to every so-called "professional" in the birth control movement.

As Kinglsey Davis has so well pointed out: "The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive, is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face the problems of social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable."

CONCLUSION

Thus the rising rates of illegitimacy and abortion are the excuses given by Planned Parenthood for fostering sex education and birth control programs. These "solutions," in turn, stimulate increased fornication, which (when coupled with high contraceptive-failure rates) leads to ever-increasing premarital pregnancy, which in turn, leads to ever-increasing rates of abortion and illegitimacy. The escalating rates of these predictable, adverse consequences are then used, once again, as justification by Planned Parenthood to call for more sex education and contraceptive programs, as the only "solution." Thus, the vicious cycle is perpetuated.

Moreover, rampant promiscuity among teenagers has also increased the incidence of VD, sterility, cervical cancer, emotional trauma, and widespread social dislocations. (This information has been documented in the *Ford Report* and other previously published articles.)

Mrs. DRISCOLL. Of particular interest to the taxpayer is the fact that teen pregnancy is reaching the highest levels in areas, particularly, I am sorry to say, in my own State of California, where the greatest public expenditures for family planning are being made. Economics professor Dr. Kasun of Humboldt University, in an article published in 1982, writes: "The data for California indicate that for every additional $1 million spent by the Office of Family Planning, almost 2,000 additional teenage pregnancies occur in this State."

This article, also, I would request be inserted into the testimony.

Mr. BLILEY. Without objection.

[The information follows:]

FAMILY PLANNING EXPENDITURES IN CALIFORNIA

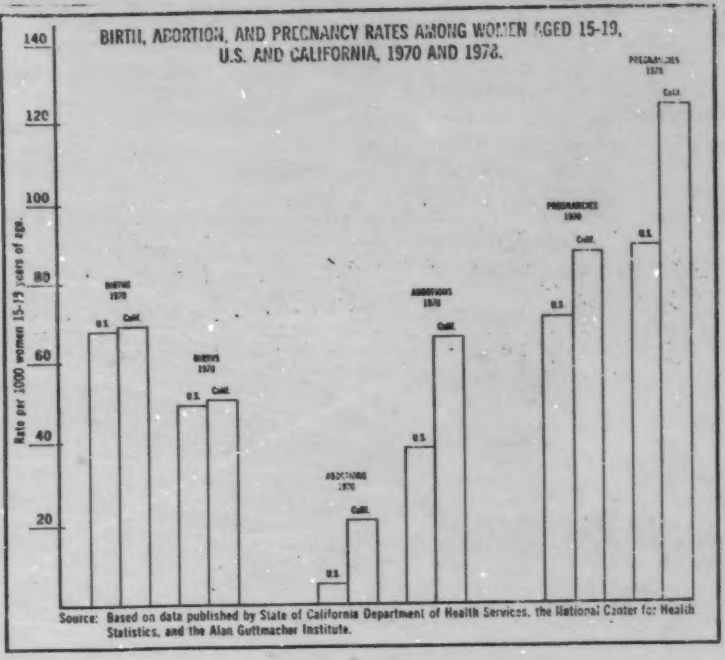
(By Dr. Jacqueline Kasun, Ph. D.)

(California data disproves the effectiveness of family planning expenditures in preventing teen pregnancies.)

The State of California is one of the foremost states in the financing and promotion of family planning, spending almost twice the amount per capita as the average for all states for this purpose and providing a higher-than-average level of availability of publicly-subsidized control services.[1] Expenditures by the California State Office of Family Planning (OFP) grew from $4 million in fiscal years 1971-73 to $35 million in fiscal years 1980-81, an eightfold expansion; during this same period federal expenditures for this purpose grew by less than half this much. In 1980-81 OFP was financing the activities of some 180 family planning agencies in 46 countries, providing funds for all methods of fertility control. In addition, the agency has for some time been actively involved in developing and promoting sex education at all grade levels including college, and has even undertaken a million-dollar television campaign to promote sex education.

The OFP has justified much of this effort on grounds of a presumed "need" for the state government to reduce levels of adolescent pregnancy. The truth is, however, first, that the OFP has seriously distorted the facts about adolescent pregnancy in making its case and, second, that adolescent pregnancy has not fallen but has increased significantly since the OFP campaign began. The evidence is that the OFP programs have in fact greatly increased the problems which they proposed to correct.

[1] Based on data published by the California State Office of Family Planning, the U.S. Department of Health and Human Services, and the Alan Guttmacher Institute.


BIRTH, ABORTION, AND PREGNANCY RATES AMONG WOMEN AGED 15-19,
U.S. AND CALIFORNIA, 1970 AND 1978.
Rate per 1000 women 15-19 years of age
140
120
100
80
60
40
20
U.S.
Calif.
Source: Based on data published by State of California Department of Health Services, the National Center for Health Statistics, and the Alan Guttmacher Institute.

Contrary to the impression given by the OFP, the birth-rate among California women aged 15-19 in 1978 was at its lowest level in decades. Most of these young mothers were over 18 and most were married. Most did not become welfare clients. Of those who did, most would receive public assistance for only a part of their needs and for only a few years or even months. Despite hysterical claims by the OFP, there is no evidence that the children of these young mothers would be less healthy or less intelligent than other children. There is no evidence that they would be abused or would become criminals or exhibit any other social pathology to a greater degree than other children.

Worse yet, however, is the fact that the very problems which the OFP essayed to correct, have grown much worse during the period of the agency's strenuous and expensive activity. The rate of pregnancy among California women aged 15 to 19 had been declining steeply during the 1960's. It began to rise, however, when the OFP began its programs to control teenage pregnancy and it has moved upward in close correspondence with increases in expenditures by OFP. As a result, the rate of pregnancy among California teenagers in 1978 was the highest of any state in the nation, more than a third above the national average.[2] The reason this very high level of pregnancies resulted in a birth rate among teenagers, that was no higher than the national average, is that the abortion rate for teenagers in this state is also the highest of any state. It has more than tripled since 1970 to a level in 1978, which greatly exceeded the rate of births among women in this age group.

Similarly among all women of childbearing age in California, the pregnancy rate has climbed to a level which is more than 20 percent above the national level, and the California abortion rate, which is 62 percent above the national average, is the highest of any state except New York.[3]

Far from discouraging "unintended" pregnancy, the OFP attempt to saturate the state with publicly-subsidized sex instruction and contraceptives has encouraged a great deal of sexual experimentation that would not otherwise have taken place. Through the highly-financed efforts of the OFP the young people of California have been brought to levels of sexual sophistication and moral "tolerance" never before seen. By offering free contraceptives and free abortions to all, the OFP has in effect invited all young people to engage in free, riskless sex and has made those who do not accept the invitation feel that they are out of step. The results are the same as they have been everywhere the experiment has been tried; significant numbers have accepted the invitation. The findings for California reinforce the results of the Roylance study which shows that, among states with similar levels of adolescent pregnancy in 1970, those which increased expenditures on family planning and sex education the most also had the highest rates of increase in teenage abortion and illegitimacy by 1978.[4]

It is clear, therefore, that the claims of the OFP that it is saving taxpayers' money are contradicted by the evidence. The evidence is that the OFP is creating more problems than it is able to solve by means of its family planning programs.[5] The data for California indicate that for every additional million dollars spent by the OFP, almost two thousand additional teenage pregnancies occur in this state. The problems which the OFP is creating with its programs are swamping the agency's ability (and perhaps everyone's ability) to correct them.

In these times of budget stringency, expenditures which cannot demonstrate their cost-effectiveness should be eliminated. Appropriations for the Office of Family Planning are clearly among these.

Mrs. DRISCOLL. Further, these sex-teaching programs have stimulated rampant promiscuity among teenagers which, in addition to causing more pregnancies, has also increased venereal disease, sterility, cervical cancer, illegitimacy and abortion, plus emotional trauma and widespread social dislocations.

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[2] Based on data published by the Alan Guttmacher Institute.

[3] Based on data published by the Alan Guttmacher Institute.

[4] Susan Roylance. Testimony before the Committee on Labor and Human Resources, U.S. Senate, March 31, 1981.

[5] Though promoters of family planning claim (with questionable validity because of a weak statistical data base) that pregnancy rates among "sexually active" teenagers are falling, the fact remains that pregnancy among all teenagers is increasing and is reaching the highest levels in areas, such as this state, where the greatest public expenditures on family planning are being made.

The Office of Family Planning, by offering free contraceptives and free abortions, has in effect invited all young people to engage in allegedly free and riskless sex, often behind their parents' backs. It has made those who do not accept the invitation feel that they are out of step.

We note with interest that Planned Parenthood's pamphlet, "Teen Sex," No. 1592, entitled "It's OK To Say No Way," points out:

First, more than one-half of our young people have not had sexual intercourse; second, many of those who are having sex do not really want to, but let themselves get talked into it; and third, the most common means and the least expensive by which adolescent females avoid becoming pregnant in these United States is by avoiding genital contact.

Yet our society does not support these abstaining adolescents or those who would like to abstain. Instead, we discriminate against the virginal male and female. We disdain or exploit them in media and advertising; ignore them in many churches; allow them to be put down by their school peers; and intimidate them by our publicly funded planned parenthood-type programs which subtly undermine their chastity choice.

Is it not time that we advocate the one sex lifestyle for our minors that can protect them and can keep them free to develop healthfully?

California's Dr. James H. Ford has presented a well organized and documented case for premarital sexual abstinence offered to the California Medical Association this year in March as a resolution. I request that this "RX: Abstinence" be inserted into the record.

Mr. BLILEY. Without objection.

[The information follows:]

Rx: Abstinence

By James H. Ford, M.D.

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Rx: Abstinence

All those fighting sex instruction programs and the contraceptive propaganda forced on our nation's youth will find most helpful Dr. Ford's well-organized presentation of the case for premarital sexual abstinence. In March, 1983, Dr. Ford offered a resolution in this form to the California Medical Association, complete with the supportive references which are provided you on the facing pages. Here, in professional detail, is the argument for the unpopular (today) practice of chastity.

The Resolution

California Medical Association Resolution 720-83, March 12, 1983: "The Foolproof Prophylactic Value of Premarital Abstinence."

1. Whereas, there are some 1.5 million legal abortions performed by physicians in this country every year; and

2. Whereas, most of these abortions are sought in order to preclude the prospect of an out-of-wedlock birth; and

3. Whereas, prevention as a solution to the problem of unwanted, untimely, or out-of-wedlock pregnancy is superior to abortion (which is frequently an unpleasant experience for the woman, and may also have significant physical, social, and emotional sequelae); and

Documentation and Notes

1. "There were 1.55 million legal abortions in the U.S. in 1980 . . . Increases in the abortion rate, which was 30.0 per 1,000 live births in 1980, are slowing; if the trend continues, the abortion rate should stabilize this year."

(Henshaw SK, Forrest JD, Sullivan E, Tietze C: "Abortion Services in the U.S., 1979-80." *Family Planning Perspectives* (14:1) Jan/Feb 1982, p 5).

2. In 1980, the number of abortions among unmarried women was 1,234,010 (or 79.4 percent of the total) as compared with 319,880 abortions (or 20.6 percent of the total) among married women.

In the same year, the abortion rate (per 1000 women aged 15 to 44 years) was 49.7 among **unmarried** women, as compared with 11.3 among **married** women. In other words, the abortion rate was four times (400 percent) greater among unmarried as compared with married women.

In the same year, the percentage of pregnancies terminated by abortion was 64.9 percent among **unmarried** pregnant women (or a 650 percent greater rate) as compared with 9.8 percent of pregnancies aborted among **married** pregnant women.

(Henshaw SK, O'Reilly K: "Characteristics of Abortion Patients in the U.S., 1979-80." *Family Planning Perspectives* (15:1) Jan/Feb 1983, Table 4, p. 8).

3. "There probably is no psychologically painless way to cope with an unwanted pregnancy whether it is voluntarily interrupted or carried to term" (p. 88).

"Certain trends emerge from a review of the scientific literature on the mental health effects of abortion. Emotional stress and pain are involved in the decision to obtain an abortion, and these are strong emotions that surround the entire procedure" (p. 98).

"Medical complications associated with legal abortion may occur at the time of abortion (immediate), within 30 days following the procedure (delayed), or at some later time (late)" (p. 67).

("Legalized Abortion and the Public Health." Report of a study by Institute of Medicine, National Academy of Sciences, Washington, D.C., May 1975)

The Resolution

4. Whereas, most of these abortions are sought in order to eliminate unwanted pregnancies, which often occur despite studied contraceptive efforts; and therefore, such abortions represent clear-cut instances of contraceptive failure; and

5. Whereas, unmarried women as a group, especially when they are very young, have a much higher contraceptive failure rate than married women (and they suffer much greater, adverse, social and emotional consequences as a result of such contraceptive failure); and

Documentation and Notes

4. "It is well recognized by now that all contraceptive methods currently in use have serious drawbacks in their efficacy, safety and acceptability. The most effective methods, the pill and IUD, have side effects . . . which have been highly publicized. As a result, contraceptive use . . . is imperfect because of existing methods, and because human beings, too, are imperfect. Nevertheless, the inadequacy of contraceptive technology is reflected in **distressingly** high rates of recourse to abortion."

(Written testimony of Faye Wattleton before Denton Title X Hearings, March 31, 1981, p. 20. Faye Wattleton is president of the Planned Parenthood Federation of America, and was testifying as the official spokesman for that organization.)

In addition, during the same Senate hearings, Wattleton admitted to Senator Nickles that the high rate of repeat abortion is a reflection of contraceptive failure which, in turn, is a reflection of the "shortcomings" in contraceptive technology:

> Senator Nickles: ". . . Do you have any statistics on the number of people that come in to have an abortion for the second time?"
>
> Wattleton: "I do not know what the statistics from our affiliates will be, but nationwide we are seeing **a repeat rate of approximately 30 percent** . . ."
>
> Senator Nickles: "Does that say anything about your effectiveness as far as pregnancy prevention?
>
> Wattleton: "It certainly says a great deal about our effectiveness in terms of the pregnancy prevention technology that is available . . . The (contraceptive) failures that we do see is (sic) a reflection of the shortcomings in technology . . . Better technology would enable fewer to face an unwanted pregnancy."

(Testimony of Faye Wattleton before Denton Title X Hearings, March 31, 1981, p. 76-77)

5. "Contraceptive use is closely related to age, in that younger women are less likely to have practiced contraception at all, or if they have used some method, to have used it less carefully and consistently than older women" (p. 119).

"Teenage women constitute a special case, in that any pregnancy, be it terminated by abortion or by full-term birth, seems to increase the risk of prematurity in subsequent pregnancies" (J.K. Russell, 1974, p. 60).

6. Whereas, many a young woman has become pregnant unexpectedly because she was deceived by a false promise of contraceptive protection (which was perceived, or inferred, to be foolproof); and

7 Whereas, premarital abstinence is the only foolproof means of preventing unwanted, out-of-wedlock

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("Legalized Abortion and the Public Health." IOM-NAS, May 1975, *op. cit.* "Whereas" No. 3)

"The health, social and economic consequences of teenage pregnancy are almost all adverse. Pregnancies that end in abortion or miscarriage are, at the least, upsetting and sometimes traumatic to the pregnant woman" ("Teenage Pregnancy: The Problem That Hasn't Gone Away." The Alan Guttmacher Institute, 1981, Section 5, p. 28).

6. Zelnik and Kantner found in their study of teenage pregnancy that:

"Among those teenagers who, in 1976, had had at least one premarital pregnancy . . . fewer than one-fourth had intended to become pregnant. At the same time, **only** one-fifth of those who had **not** intended the pregnancy reported that they had been contracepting regularly to prevent it. (. . . This is perhaps a surprisingly low level of contraceptive practice among those who wish to avoid pregnancy . . .)

"(Of those) who had not intended to become pregnant and had been 'regularly' contracepting, 36 percent had used the pill . . . (While) 55 percent of **nonusers** (of contraceptives) had **thought they were likely** to become pregnant . . . , (by comparison) **most of those** who had taken the pill **did not think** that there was a good chance they would become pregnant" (but they became pregnant anyway) (emphasis added).

(Zelnik & Kantner: "First pregnancies to women aged 15 to 19; 1976 and 1971." *Family Planning Perspectives* (10:1) Jan/Feb 1978, p. 14.)

Furthermore, according to a study by Dr. Laurie S. Zabin, vice-chairperson of the Alan Guttmacher Institute: Even among teenagers who are contracepting in the most ideal and consistent manner, with the most medically-effective contraceptives; the **minimum**, theoretical, two-year-cumulative pregnancy-risk is estimated to be 13.6 percent. (*Family Planning Perspectives*, March/April, 1981, p. 73).

By comparison, among teenagers who abstain consistently, the pregnancy risk is, quite obviously, and also quite strikingly, **absolute zero!**

7 Furstenberg *et al*, speaking for the Alan Guttmacher Institute, points out that "only the most optimistic planners believe that

pregnancy (and incidentally, it thereby prevents, as well, the many kinds of social dislocation associated with such pregnancy); and

8. Whereas, even though we are all quite aware that "abstinence" is seen as a joke word in some sectors of our society; it has, nevertheless, been strongly endorsed as a desirable and reliable health measure by others (e.g., the AMA); and

9. Whereas, in 1974, the AMA (in Report T of the Board of Trustees) adopted as policy "the need to encourage the use of all practical . . . methods of prevention . . . of gonorrhea and other venereal diseases . . . including fidelity and continence in married couples and abstinence in unmarried individuals;" and

10. Whereas, "abstinence in unmarried individuals" could also be quite effective as a health measure in stemming the tide of unwanted out-of-wedlock pregnancies and abortions—if such abstinence were more frequently, vigorously and unequivocally encouraged by opinion leaders and authority figures in our society; and

family planning and sex education and contraceptive services by themselves will reduce adolescent births to an insignificant number . . . . Given the many reservations that teenagers have about birth control, the ambivalent feelings that often accompany nonmarital sexuality, and the psychological propensity of many adolescents toward risk-taking, we may expect a substantial . . . rate of premarital pregnancy in years to come . . . . Only good luck, coupled with an increase in research dollars, will give us a safe contraceptive method more suited to teenagers, for whom sex tends to be episodic and unexpected, than those currently available."

(Furstenberg FF, Lincoln R, Menken J: "Overview," *Teenage Sexuality, Pregnancy and Childbearing:* Univ. of Pennsylvania Press, Philadelphia, 1981, p. 14)

8. Efforts by some parents and church groups to encourage premarital abstinence among young people have been ridiculed by various spokesmen associated with other groups, calling themselves "the foremost agents of social change" in the area of sexual liberation. Such traditional efforts have been sarcastically disparaged as "exhortations" and "proscriptions."

(Furstenberg *et al*: in "Overview," *Teenage Sexuality, Pregnancy and Childbearing* (Univ. Penn. Press, Phila. 1981, p. 15)

9. "The American Medical Association's House of Delegates has developed policy positions that favor chastity as a prophylactic measure . . . The delegates endorsed 'abstinence' for single people and 'fidelity and continence' for married couples . . ."

(News report: "AMA Says Chastity Can Avert Gonorrhea." *Family Practice News*, August 15, 1974. Note: "Continence" means "self-restraint," or the ability to refrain from some bodily activity.)

10. Even Freud, although he felt that the mental mechanisms of denial and repression of impulses were harmful to the psyche, did not disparage the value of sublimation, or the conscious suppression of impulses. Freud also suggested that maturity was characterized by the ability to postpone gratification, and he clearly rejected immaturity, infantilism and narcissism as disvalues in the area of psychological adjustment and personal adaptability in life.

Therefore, even in terms of the Freudian ethic, many if not most of the young people who are currently addicted to a sexually active lifestyle are behaving not only immaturely, but perhaps, in a

manner ultimately detrimental to their mental health.

These suggestions about the immaturity, confusion and the inadequacy of most adolescents is confirmed by their own statements as found in the *Sorenson Report: Adolescent Sexuality in Contemporary America* (1973). Although 75 percent of adolescents objected "when people think of me as an adolescent" and 83 percent resented it "when older people think of me as a child," quite incongruously, 73 percent of them agreed that "I'm not a child anymore, but I'm not an adult yet, either." Furthermore, 61 percent of boys and 65 percent of girls admitted that they still "think and act somewhat like a child."

And 47 percent of adolescents admitted that they would have a hard time going out into the world on their own, and 37 percent think of themselves as children because there are a lot of things that they still can't do on their own. Then, 36 percent of boys and 27 percent of girls agreed that "the way I'm living right now, most of my abilities are going to waste."

Furthermore, 50 percent of non-virgin adolescents worried about whether God would approve of their sexual activity; and 54 percent believed that some of their sexual activities were probably harmful to their relationship with their parents.

Then, 28 percent of non-virgin adolescents believed that some of their sexual activities were harmful to them; and 34 percent said: "Sometimes I think that I am addicted to sex the way some people are addicted to drugs." Then, 58 percent of non-virgin adolescents agreed: "When it comes to sex, a lot of young people these days do the things they do just because everyone else is doing it;" but paradoxically, 54 percent agreed: "My sexual behavior would not be acceptable to society."

Then, 46 percent of all non-virgins agreed: "Having sex helps take my mind off some of the bad things that happen to me." And 52 percent of older boys, and 74 percent of the older girls agreed that some boys use sex to reward or punish their girl friends. And 71 percent of the older boys and 74 percent of the older girls agreed that some girls use sex to reward or punish their boyfriends.

This frequent misuse of sex, and the nonsexual motivation in much of adolescent sexual behavior, was also noted by Cohen and Friedman ("Nonsexual motivation of adolescent sexual behavior," *Medical Aspects of Human Sexuality*, Sept. 1975). They found that adolescents often have ego and identity problems. Those who feel

The Resolution

11. Whereas, the social supports which fortify the morale and resoluteness of those attempting to adhere to the traditional norm of premarital abstinence are being ever more seriously eroded by the mixed messages and double-talk emanating from some quarters of our society on this subject; and

inadequate and unacceptable often engage in sexual activities to gain peer approval.

Cohen and Friedman also noted that adolescents use sexual activities to rebel against parents and to "get even" with them for real or imagined grievances. Adolescents were also found to use sexual activities or pregnancy to escape from a life situation or to get away from home. They also found that sexual activities could be a cry for help, a search for love or an act of self-destruction. They concluded: ". . . It appears likely that the pattern of resolving non-sexual conflicts is detrimental to the development of true intimate interpersonal relationships in adolescents and young adults."

11. The Planned Parenthood Federation of America (PPFA) in its pamphlet "Teensex" tells teenagers that "it's okay to say no way." But, although PPFA admits that saying "No" isn't easy, and tells teenagers that premarital coitus **"may"** even have "sad results," the ambiguous language used by PPFA in most of its discussion on the subject of self-restraint tends to subvert, in advance, any possible resolution the ambivalent teenagers might decide to make in favor of saying "No." It does this by leaving with the teenage reader the distinct impression that it is **equally** "okay" to say "Yes"—when you are "ready to," or "want to," or "decide to" (PPFA pamphlet No. 1592).

In a related but probably contradictory ploy, spokesmen for the Alan Guttmacher Institute (research arm of PPFA) tell us that "in order to avoid corrupting the young and sexually inexperienced, sexual information too often is not given to the teenager until it is too late to prevent the first pregnancy" (p. 15).

In order to remedy this flaw in their teenage fertility-control program, these spokesmen suggest that premarital coitus be treated as the norm (p. 14), and that "society will have to make the difficullt decision to transmit the knowledge and the means of pregnancy prevention to **all** teenagers—not just those known to be sexually active. There is the chance that some, thereby, may be encouraged to experiment with sex somewhat earlier than they would have done otherwise . . ." (p. 15). They further suggest that family planning programs be made "more accommodating to the adolescent life-style" (p. 15).

(It should be noted here that such policy not only discriminates against those who are trying to abstain and in favor of those who have no desire to resist temptation, but it also heavily loads the

12. Whereas, we see too few of our opinion leaders, nowadays, applauding the ideal of self-mastery, or suggesting that we encourage such an ideal in our young people; and

13. Whereas, there also appears to be a crying need to promote a return to greater decency and sanity (and a corresponding need to discourage the worsening trend toward sexploitation) in male-female relationships; and

choice, in every way, in favor of saying "Yes" to premarital coitus.)

Finally, these same spokesmen admit that "even the most dedicated proponents of widespread contraceptive information and availability for teenagers are aware that their efforts may promote sexual activity, even while they are reducing pregnancy among the sexual active . . ." (p. 21). (Furstenberg *et al. Teenage Sexuality, Pregnancy and Childbearing*, Univ. Penn. Press, Phila., 1981)

12. As physicians who are concerned with advancing the public health in the areas of pregnancy-prevention and mental health, we would be acting in the finest tradition of our profession, and would be promoting the best health interests of our patients (and the citizenry at large), if we were to give strong encouragement to those who are struggling, in a spirit of exemplary excellence, to sublimate their sexual impulses and to postpone gratification in the hope of attaining a healthier, happier and more stable future in a marital relationship.

13. Media periodicals and reports are replete with stories about the escalating intensity of hostilities, disillusionments and disenchantment in relationships between the sexes. For example, a recent report in *U.S. News and World Report* (Feb. 21, 1983) tells about the frustration and disillusionment that exist within the nonmarital relationships among the 19 million "singles" that now reside in this country. "Later marriage and more divorces are fast swelling the ranks of Americans living alone—an experience that seems to be liberating for some—but depressing for others."

In a similar vein, reports about the sexploitation going on between the sexes continue. Such reports, even when limited to the medical literature, are too numerous to cite adequately in any reasonably brief summary of the current situation.

In 1967, a University of Wisconsin psychiatrist pointed out that the promiscuity which was occurring as a result of the new permissiveness had had a disastrous effect on the mental health of many female college students.

He pointed out that young women had not only been victims of the exploitative behavior of their male companions but also of their own self-deception. He called these young women "casualties of the sexual revolution."

(Halleck SL: "Sex and mental health on the campus." *JAMA* (200:8), May 22, 1967, p. 108)

Documentation and Notes

Since then, the situation has obviously become much worse. A more recent study documents the same complaint, i.e., that many college women have been flagrantly exploited by their sex partners.

(Weis DL: "Reactions of college women to their first coitus." *Medical Aspects of Human Sexuality* (17:2) Feb. 1983, p. 60cc.)

In 1974, a poll of 15,000 family physicians and psychiatrists revealed that many if not most of them believed that the new morality and the sexual revolution had created a moral climate that has been, on balance, harmful to the physical and mental well-being of their patients; and furthermore, that this permissive climate had contributed significantly to an increased incidence of VD, rape, unwanted pregnancies and abortions.

(Kirk J: "Four questions about sex in our society." *Medical Times* (Vol. 102, No. 11), Nov. 1974, p. 68)

And revelant to the increasing levels of premarital coitus going on among our young people, a prominent demographer (Charles Westoff of Princeton) has suggested that "the future seems less and less compatible with long-term traditional marriage . . . there seems to be a massive postponement of marriage in the making . . .

"The intriguing question is whether we are witnessing a postponement of marriage, with an institutionalization of trial marriage, or a more basic change that will eventually alter the institution itself. . . . There do not seem to be any forces in view that will reverse this trend . . . ."

(Westoff, Charles: "Some speculation on the future of marriage and fertility;" Chapter 10, p. 155, as found in Furstenberg *et al* (ed.): *Teenage Sexuality, Pregnancy, and Childbearing* (Univ. Penn. Press, Phila., 1981)

In this context, a leading (Columbia University) sociologist has warned that "at the present accelerating rate of depletion, the United States will run out of families not long after it runs out of oil . . . Depending on one's assumptions about how this accelerating disintegration of the family will progress, the U.S. will not have a married household left a generation or so from now.

"This is not to be taken as a prediction; it simply projects a past trend into the future at the same rate of acceleration. The projection suffices, however, to show that the family is an endangered species, which it may require a conscious, collective effort to save—as part of our social ecology. Clearly, if this decline (in family formation and stability) is not to continue, some powerful forces will have to inter-

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14. Whereas, a recent poll reveals (despite the alleged inroads of the sexual revolution) that most America women not only believe in premarital abstinence as a good policy and a desirable norm, but also strongly disapprove altogether of premarital sex; and

15. Whereas, neither the media, nor public agencies, nor concerned professonal groups have as yet placed adequate emphasis on premarital abstinence as an important, preferred and readily available method of precluding unwanted, out-of-wedlock pregnancy and abortion; now, therefore be it

Resolved: **That the CMA endorse the proposition that premarital abstinence is a most desirable and effective means of precluding unwanted pregnancy, out-of-wedlock births, abortion, forced marriage and other similar kinds of social dislocation; and, be it further**

Resolved: **That the CMA urge the media, the appropriate public agencies, and all concerned professional groups to emphasize, in their educational campaigns to the public, the benefits of premarital abstinence as an effective and readily available means to reduce the incidence of abortion, as well as other kinds of social dislocation associated with unwanted, out-of-wedlock pregnancy; and be it further**

Documentation and Notes

vene to reverse the trend."

(Etzioni, Amitai: "Science and the future of the family," *Science* (Vol. 196, No. 4289), April 1977)

14. A recent poll by *Glamour* magazine found that 51 percent of the women polled considered premarital sex to be "unacceptable." Furthermore, only 20 percent "strongly agreed" that it was acceptable. This story was reported not only by UPI (*L.A. Times*, Dec. 19, 1982) but also by AP (*Los Angeles Herald Examiner*, Dec. 14, 1982).

There have been other polls with similar results. In 1976, a National Opinion Research Center poll found that almost 70 percent of adult Americans believe that intercourse outside marriage is "always wrong" (News item: *Sexual Medicine Today*, May 1982, p. 5).

The Resolution

Resolved: **That the general tenor of this resolution be presented this year to the AMA House of Delegates for consideration and approval.**

Epilogue

Unfortunately, Dr. Ford's efforts to present a pro-family resolution to the California Medical Association were rudely received by some of his fellow delegates and members. His proposed resolution went nowhere at the CMA convention, derision filled the air, and Dr. Ford went home understandably hurt and considering resignation from the CMA.

Recognizing that his voice is badly needed in that assembly, however, he has since determined to stay and keep fighting the battle. As he remarked at the time, how he was treated is not the real issue: **"I'll get over it! But millions of young women who will have to live with the consequences of the problem throughout their future lives will not!"**

You can be sure that members of the CMA will hear again from Dr. Ford about the value of abstinence from premarital sex. Let us hope that more and more of them will begin to listen, so that they can join him in properly educating the teenagers of California.

Of course, the same arguments can be used to promote abstinence before any state medical body, and before any local agency that has influence on classroom sex education. If you are part of the fight to defend teenagers against what Dr. Paul Ramsey calls "the insistent society," Dr. Ford's resolution can buttress your own work.

Mrs. DRISCOLL. Dr. Ford urges the media, appropriate public agencies, and all concerned professional groups to emphasize in their educational campaigns to the public the many benefits of premarital abstinence.

With this as background, I shall overview two grassroots movements which are clearly promoting abstinence. One is called Christian Womanity—hereinafter referred to as Womanity—and Teen-Aid, Inc.

Womanity, of which I am a founder and the director, means Women for Humanity. A California-based volunteer, nonprofit educational service, we began over 10 years ago with a program for teenaged girls affirming their dignity and value. The message of self-esteem and personal responsibility was extended to include boys.

Today, Womanity Publications are ordered and used throughout the United States and in Canada, Australia, and England.

In 1982, Womanity presented an accredited seminar for nurses, educators, and parents in San Francisco. Entitled "Affirming Adolescent Abstinence," the conference drew over 300 professionals from 9 States. Orders for the tapes and publications are still being received nine months later.

A follow-up seminar, entitled "Teaching Sex Respect," is scheduled for October 29 of this year, also in San Francisco.

Womanity materials are ordered by public and private schools, churches, youth ministers, health departments, school district, hospitals, Crisis Pregnancy Centers, Pro-Life Groups, as well as teachers, parents, doctors and counselors and, laughingly enough, even the military.

In response to requests last year we have sent out 280,000 pamphlets and we fill monthly from 100 to 300 orders. One of the interesting developments is that increasing numbers of requests are coming from the Pregnancy Crisis Centers to assist unmarried teens in changing their sex life style.

Teen-Aid is another alternative to the Planned Parenthood approach and it, too, is a nonsectarian and nonprofit Spokane, Washington-based group. Teen-Aid was organized in 1981 and it is committed to encouraging abstinence as a premarital life-style for teens.

Abstinence conveys a far deeper meaning than the restraint of an impulse. It relates to a belief in the family and in the ultimate value of human life and reflects the respect for self and for one's future spouse and children.

About 500 copies of the Teen-Aid's High School curriculum, which is entitled "Sexuality, Commitment and Family," and was designed for public schools have already been purchased by people in over 26 States and 6 Canadian provinces.

The large numbers of parents and teens who want to resist the trend toward sexual license is reflected in Teen-Aid's rapid growth.

At this point, I would like to request that in the record reference to the article on Teen-Aid be included.

Mr. BLILEY. Without objection.

[The information follows:]

[What's Working: A review of new ideas and events in pro-life service]

TEEN-AID: VALUE-FULL SEX EDUCATION

(By Nancy Roach)

Each of us in the Pro-Life Movement has a unique set of experiences that account for his or her sustained commitment of the sanctity of life. In 1981, significant events in Eastern Washington touched the lives of key pro-life activities and produced a powerful sense of unity, rededication and shared vision.

During that year, several communities were polarized by issues centering around the teaching of value-free sex education and the inviting of Planned Parenthood to increase their efforts to provide contraceptives to teens. After weeks of "protest" activities, it became clear that an alternative approach to the adolescent pregnancy problem needed to be developed. The opportunity to build the framework for such an alternative came in August, 1981, when representatives from eleven Eastern Washington communities met to share resources and ideas, and to plan a positive response to the value/free, contraception-oriented programs for teens in their communities. Teen-Aid was born.

The principles guiding the new organization were set down in a charter that clearly states Teen-Aid's commitment to encouraging abstinence as a premarital lifestyle for teens. But as Teen-Aid's non-sectarian programs have evolved, abstinence has conveyed a far deeper meaning than the restraint of an impulse. It relates to a belief in the family and in the ultimate value of human life, and reflects a respect for self and for one's future spouse and children.

Along with the Teen-Aid charter, the original board identified five basic program elements. Briefly stated these are:

1. Media Campaign—to utilize all available media to promote the benefits of abstinence as a premarital lifestyle for teens; and to assist parents in communicating about human sexuality, with their children.

2. Community Education—to make available to the community (e.g., schools, churches and families) a curriculum in human sexuality, complete with bibliography; to provide audio-visual materials for the course, and to train volunteers to present to individual classes, the nature and objectives of Teen-Aid.

3. Operation Communication—to provide workshops for parents, on the subject of human sexuality designed to improve parent-teen communication, and to sponsor workshops for teens to assist them in formulating and expressing their choice to avoid premarital sexual activity.

4. Individual Counseling—to offer help to teens seeking a framework for understanding their sexuality.

5. Medical Services—to provide screening for sexually transmitted diseases (STD), with the provision that all clients screened must receive counseling as to the advantages of premarital abstinence. Pregnancy testing will be available upon request. All clients with positive results will be referred to a pro-life pregnancy counseling service.

In October of last year, Teen-Aid reached a major milestone by completing the senior high curriculum, Sexuality, Commitment and Family. Designed primarily for use in the public schools, this fifteen day course is aimed at encouraging respect for the power to procreate and unequivocally presents abstinence as the most beneficial lifestyle for unmarried teens. Steve Potter, the senior editor of the curriculum, has been a high school teacher and coach for ten years and has witnessed the damaging effects of value-free sex education programs. Sexuality, Commitment and Family is unique in that it does not include information on the mechanics of birth control, and encourages parental involvement through the "Parent/Teen Communicators" that are sent home with the students at the end of each lesson.

The Teen-Aid counseling program got underway this January when our first office was opened in Spokane. Averly Nelson, M.D. (Psychiatry) and Frank Hamilton, Ph.D. (Clinical Psychology), have developed guidelines used in training our volunteers. Dr. Nelson says of our counseling program: "It is designed to afford to teenagers a sense of structure and meaning so that they will direct their energies toward the development of skills and character traits that will provide a bedrock of security as they enter into the responsibilities of early adulthood".

Our Spokane staff is committed to helping teens become involved in positive, constructive activities, and are informed as to existing community programs and job opportunities.

In September, our Spokane office will begin providing STD screening. This will be under the direction of Al Derby, M.D. (ob-gyn), who has written extensive medical guidelines for our counselors.

The response to the Teen-Aid concept has been, at times, overwhelming. The countless requests for speakers, materials, curricula and additional services have been, to us, a clear sign that teens want to be challenged to avoid sexual activity, and that parents are anxious to help them meet that challenge.

There are currently eight Teen-Aid affiliates (five outside of Washington state) with several other communities doing the groundwork to get affiliates started. Our curriculum has been purchased by people in 26 states and six Canadian provinces. Letters of interest and support are received daily.

As we continue to develop our programs, the Teen-Aid board is in close contact with existing pro-life organizations to insure that efforts aren't duplicated, and that a spirit of cooperation is maintained. Nearly every board member has brought to Teen-Aid, experience in some facet of the Pro-Life Movement. This experience has made each of us aware of the vital need for sexuality education that supports traditional mores and encourages strong family ties.

It has been said that trend is not destiny. The large numbers of parents and teens who want to resist the trend toward sexual license, is reflected in Teen-Aid's rapid growth. With the help of those who find hope and support in our message, Teen-Aid may soon become a significant force in the pro-life effort to reshape our destiny.

Mrs. DRISCOLL. Thank you.

In conclusion, I urge that the United States stop funding those agencies like Planned Parenthood, which have failed to reduce the teen sex problem. I urge that we initiate a national nonsectarian program of support for premarital fidelity, a new image for adolescent abstinence.

Creative programs, mass media campaigns, agencies and services could all affirm this reasonable, natural and healthy sex lifestyle for our minors.

Results are predictable: Promiscuity, pregnancy, and abortion will drop. Individual and social health will improve.

So, for the benefit of our children, our families, and our Nation, I urge the official affirmation of adolescent abstinence.

Thank you.

[The prepared statement of Patricia Driscoll follows:]

PREPARED STATEMENT OF PATRICIA WALKER DRISCOLL, DIRECTOR, WOMANITY, WALNUT CREEK, CALIF.

Chairman George Miller and Members of this Committee, I want to thank you for the opportunity to testify as a citizen, a taxpayer and a concerned parent on the vital issue of adolescent pregnancy prevention.

I am here to try to convince you to bring the full power of the Federal Government to promote a foolproof method of reducing teen pregnancy specifically, abstinence.

First I would like to show the irrationality of the present government policy by contrasting how we deal with two teen problems, teen shoplifting and teen sex:[1]

Teen shoplifting is a growing social problem but we do not fund programs to promote responsible shoplifting so that those who choose to shoplift can learn how to do so without getting caught.

But we are doing just that with the teen sex problem. Government-funded programs such as the Office of Family Planning and Planned Parenthood claim to be promoting responsible sex, by teaching contraception and abortion. They teach our teens how to have sex but not get caught.

And the result? The youth are getting caught. The teen sex problem is worse than ever.

In an editorial of Family Planning Perspectives—Sept./Oct. 1980—Zelnick & Kantner show that more teenagers are using contraceptives and using them more meticulously than ever before. Yet the number of pre-marital pregnancies continues to rise.[2]

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[1] "Teach Them To Steal * * * But not get Caught." Womanity, Walnut Creek, Calif., 1980.
[2] "Teenage Pregnancy, Contraception and Abortion." James H. Ford, M.D. Heartbeat, Summer 1983, pp. 10-12.

Of particular interest to the taxpayer is the fact that teen pregnancy is reaching the highest levels in areas (particularly California) where the greatest public expenditures for family planning are being made. Economics Professor Dr. Kasun of Humboldt University in an article published in 1982 writes "The data for California indicate that for evey additional million $'s spent by the OFP, almost 2 thousand additional teenage pregnancies occur in this state." [3]

Further these sex-teaching programs have stimulated rampant promiscuity among teenagers which, in addition to causing more pregnancies has also increased V.D., sterility, cervical cancer, illegitimacy and abortion plus emotional trauma and wide spread social dislocations.

The Office of Family Planning by offering free contraceptives and free abortions has in effect invited all young people to engage in allegedly free and riskless sex—often behind their parents' back.

It has made those who do not accept the invitation feel that they are out of step.

We note with interest that Planned Parenthood's pamphlet "Teen Sex—It's Okay to Say No Way" points out:

(1) More than one-half of our young people have not had sexual intercourse.

(2) Many of those who are having sex don't really want to but let themselves get talked into it.

(3) The most common means and the least expensive by which adolescent females avoid becoming pregnant in the U.S. is by avoiding genital contact.

Yet our society does not support these abstaining adolescents or those who would like to abstain! Instead we discriminate against the virginal male and female. We disdane or exploit them in media and advertising; ignore them in many churches; allow them to be put down by their school peers; and intimidate them by our publicly funded Planned Parenthood type programs which subtly undermine their chastity choice.

Isn't it time we advocate the one sex life style for our minors that can protect them and can keep them free to develop healthfully?

California's Dr. James H. Ford has presented a well organized and documented case for pre-marital sexual abstinence, offered to the California Medical Association as a resolution in March 1983. I request that "RX: Abstinence" be inserted into the record.[4]

Dr Ford urges the media, appropriate public agencies and all concerned professional groups to emphasize in their educational campaigns to the public the many benefits of pre-marital abstinence.

With this background, I will overview two grassroots movements which are clearly promoting abstinence: Christian Womanity (hereinafter referred to as Womanity) and Teen-Aid, Inc.

Womanity (of which I am a founder and the director) means Women for Humanity. A California-based volunteer, non-profit educational service, we began over 10 years ago with a program for teenaged girls affirming their dignity and value. The message of self-esteem and personal responsibility was extended to include boys. Today Womanity publications are ordered and used throughout the United States and in Canada, Australia and England.

In 1982 Womanity presented an accredited seminar for nurses, educators and parents in San Francisco. Entitled "Affirming Adolescent Abstinence," the conference drew over three hundred professionals from nine states. Orders for the tapes and publications are still being received nine months later. A follow-up seminar "Teaching Sex Respect" is scheduled for October 29, 1983, also in San Francisco.[5]

Womanity materials [6] are ordered by public and private schools, churches, youth ministers, health departments, school districts, hospitals, Crisis Pregnancy Centers, Pro-Life Groups, teachers, parents, doctors, counsellors—even the military!

TEEN-AID

Another alternative to the Planned Parenthood approach is Teen-Aid, Inc. A nonsectarian and non-profit, Spokane, Washington-based group, Teen-Aid was organized in 1981. It is committed to encouraging abstinence as a pre-marital life style for

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[3] "Family Planning Expenditures in California." Dr. J. Kasun, Ph.D. Heartbeat, Winter, 1982, pp. 12-13.

[4] "RX: Abstinence," James H. Ford, M.D.

[5] "Teaching Sex Respect"/flyer. Womanity, Oak Park Center, Pleasant Hill, CA 94523.

[6] Sample Womanity leaflets: "On the Verge of Virginity," "Gone all the Way, Now Where?", "How to Say No," "Secondary Virginity," "The Best Birth Control for Teens," "Parent Power and Teen Sex."

Teens. Abstinence conveys a far deeper meaning than the restraint of an impulse. It relates to a belief in the family and in the ultimate value of human life and reflects a respect for self and for ones future spouse and children.

Five hundred copies of the Teen-Aid's High School Curriculum, "Sexuality, Commitment and Family," designed for public schools have already been purchased by people in 26 states and 6 Canadian provinces.

The large numbers of parents and teens who want to resist the trend toward sexual license is reflected in Teen-Aid's rapid growth.[7]

CONCLUSION

I urge that the United States stop funding those agencies like Planned Parenthood which have failed to reduce the Teen Sex Problem.

I urge that we initiate a national non-sectarian program of support for Pre-Marital Fidelity—a new image for Adolescent Abstinence. Creative programs, mass media campaigns, agencies and services could all affirm this reasonable, natural and healthy sex life style for our minors.

Results are predictable: promiscuity, pregnancy and abortion will drop. Individual and social health will improve.

So, for the benefit of our children, our families and our nation I urge the official affirmation of adolescent abstinence.

Mr. BLILEY. Thank you very much.

Ms. Jones, for a number of years, it appears that adolescents were not choosing adoption as an alternative. In your experience, is that situation changing at all?

Ms. JONES. No.

Mr. BLILEY. Do you have any recommendations in terms of how adoption might also be included as a viable alternative in dealing with the problem?

Ms. JONES. Well, it certainly does not deal with the problem of pregnancy prevention. On a more direct basis, are you talking about the problem of teenagers incapable of raising their own children?

Mr. BLILEY. We, of course, are talking about problems as they affect their youth and in prevention strategies, oftentimes the natural mother is not equipped to handle the baby that she has. That is one of the reasons, for one reason or another, be it financial or be it emotional or whatever. That is, of course, one of the major reasons why we have adoption in the first place.

Ms. JONES. We are looking more carefully in the literature over the last several years about age differences and parenting ability. Some of the studies that we have conducted at Columbia clearly indicate that socioeconomic status seems to be a greater indicator of inability to cope as a parent than age.

We would be, therefore, hard-pressed to say that we would encourage young people to put their babies up for adoption. Obviously we feel that they need extra support systems, but we do not believe that that is a viable alternative and would not be encouraging.

Mr. BLILEY. Ms. Jones, your testimony stresses the importance of having the local community involved in successful prevention programs. Do you think it is either appropriate or productive for the Federal Government to set a national agenda that specifies what should be included in local prevention programs?

Ms. JONES. No, except within a broad framework, I do not think that the Federal Government should be doing that. I think it is important that these programs be developed at the community level.

[7] "Teen-Aid, Value-Full Sex Education," Nancy Roach. Heartbeat, Summer 1983, pp. 22-23.

However, I do believe it is the Government's responsibility to be sure that there are funds available so that services can be provided in these communities and then let the community determine how they will evolve.

Mr. BLILEY. Ms. Jones, you say that prevention through education needs to begin before the teenager is sexually active. Do you think this education should be established by uniform curriculums and national policies that require adherence to certain kinds of educational programs?

Ms. JONES. Once again, I truly believe we need a national agenda that focuses on prevention, but I think it is important that these programs be developed at a community level. For example, the cultural and social framework of Washington Heights, with a large Hispanic, newly arrived population, is very different from that in Harlem, for example. I think that if one would say that the programs which we have developed have any measure of success, it is because they have been developed within a community context.

Mr. BLILEY. Thank you.

Mr. Weir, would you please tell us from your own experience what you believe to be the major components which are essential to reaching the hearts and minds of young people and turning them from a course which will only bring trouble?

Mr. WEIR. I do not think there are any "major components." I think there is "a major component" and that would generally be in the form of another human being. Our experience goes back to the root level of having worked very directly on the streets of a number of the major cities around the country with young people involved with all kinds of socially unacceptable behavior, from drugs to juvenile delinquency, adolescent pregnancy, and so forth.

We have come to the conclusion, without a lot of supported research, that most of this behavior falls within the category of either acting out or seeking to have a need fulfilled. We do not make it much broader than that as maybe others have made that need—or try to describe that need as something that peer pressure can play on and other things to influence a kid's behavior, whether it is someone who does not say "no" to sexual advances, or "no" to a peer group that says to use drugs.

I think what we have seen that works is when another caring, supportive human being, not only through attitude and personality, but by way of his or her own example, can impact on that life in a one-on-one relationship.

I give a lot of credit to programs like "Big Brothers or Big Sisters," where they put a kid, or young person, in direct relationship to another model of proper adult maturity and responsibility as a visible example that he can—he or she—can look at.

Within the framework of larger programs, I think sometimes we lose that element as we become less personal, as I described in my report, and I think that that element can be consciously built back into many of the programs, regardless of who the provider is; whether it is a master degreed social worker, physician, nurse, teacher. When we start to deal with people in bulk and as groups, then we lose the very essential element that they are seeking to begin with, which is the human contact.

Mr. BLILEY. Can you tell us a little bit more about your outreach efforts; how you go about reaching the young people.

Mr. WEIR. What we have done, again, using existing resources, many of the agencies and institutions, to one degree or another, have access and have their hands on the population that we are trying to reach. In many cases, however, they are not prepared or geared with the services or resources themselves to impact directly at the point that they have the kid. What we attempt to do is go into those places on a favorable basis by having those who already work with those kids and have their confidence provide the initial introduction and relationship for us.

Through that, we will follow up continually until we begin to earn the right to be heard—the confidence of the groups that we are trying to reach.

Over a 2-year effort, the result of that has been that our program has won a great deal of respect from the target population. At this juncture, we are known in the community; we are respected, and the kids are the greatest referral that we have right now, coming from the initial bodies that we have worked so hard to gain relationships with.

I should point out here again that the idea in doing that was that we assign staff with the specific responsibility of getting to know the young people who they were going to be working with and touching later on. So, in those personal relationships, it has paid off handily in multiple referrals and confidence-building.

Mr. BLILEY. One notable feature of your program is that you include not only the adolescent female, but the males and the families.

Mr. WEIR. Correct.

Mr. BLILEY. Can you address why you feel that this broad approach is so important?

Mr. WEIR. First and foremost, speaking to the idea of family, which would lead back to the male, we do hold to the idea that the family, as the core institution of the society, and also the core institution for developing human beings that are produced in this society, has been in many ways, by the very good intentions of policymakers at all levels of Government, and private organizations who have sought to intervene in crises that have hit families, have inadvertently and gradually—and to the point now that it has been totally accepted—stripped the family of its basic function and role.

This pendulum has swung too far the other way. In that belief that many of the problems we now see borne out of that, not only in the area of adolescent pregnancy, can find some of their solution, or a good part of their solution, in knitting the fabric of that institution.

We, therefore, believe that in any of the problems that we approach with young people, we are generally looking at manifestations of problems that have developed in that basic unit for its lack of cohesiveness. In attempting to deal directly and only with the adolescent, we feel that we would be applying a Band-Aid or, in effect, dealing with the problem superficially. Going into a family by touching any member of it, I think, we have an obligation to address all the members who have a responsible concern with the individual that we are dealing with.

The same holds true, therefore, again with the male, but whatever potential exists there, not promoting marriage for teenage mothers to the father if the relationship does not suggest that on its own, but some formal accommodation of his need in relationship to that situation and to seek him out as an important factor down the line in the development of that young lady's situation and that child that he has helped bring into the world.

Mr. BLILEY. Thank you.

Mrs. Driscoll, do you know of any research that has systematically examined the effectiveness of programs designed to prevent adolescent pregnancy by other than the use of contraceptives?

Mrs. DRISCOLL. No, I do not, and nobody else does, either.

Mr. BLILEY. Ms. Driscoll, Mr. Weir has suggested that we tolerate and encourage more diversified localized approaches to many youth-related problems. Do you share that opinion, and can you suggest ways in which we might encourage a more localized approach to the problems of teenage pregnancy?

Mrs. DRISCOLL. Yes, that was a wonderful thing and I listened intently to what he was saying. This is a grand thing to do and I would like to suggest that we have tried to do a little creative activity in that regard ourselves.

Christian Womanity has plugged into a local television public community access station, channel 19, in Martinez. This community station offers to members of the community up to 1½ hours of production time to produce up to a half-hour television show. This is a service which is offered, and is a grand opportunity to get messages across.

I am happy to say that since January, Womanity has produced seven half-hour programs utilizing this community service.

Mr. BLILEY. We know that young people are greatly affected by peer pressure, Ms. Driscoll. What has been the experience of your organizations in witnessing the effects of peer pressure?

Mrs. DRISCOLL. This is a big problem which all testimony today has dealt with. One of the things which womanity is trying to do, and also the teen-aid program, is to identify the components of peer pressure and to train the young people to be assertive, to identify their standards and values, and to be able to stand up for them.

This is a very important service which we can give to our young people, and we have found that they have been very responsive. We have some of our own little leaflets. For example, this is a very popular one, "How to Say No Without Losing His or Her Love."

I would like to mention, also, that this flyer has been translated into French for Canadian people, and we even received a request from a doctor in South Africa to give him permission to translate it into several of the native languages. But basically, we give suggestions here to the young people, not only the girls, but the boys, too, as to how to say "no" in effective ways.

We are helping them to learn how to stand up for what they believe.

Mr. BLILEY. Thank you very much.

I want to thank you, Mrs. Jones, Mr. Weir, Mrs. Driscoll, for being with us. I know that my colleagues have a lot of questions that they will probably send you in writing and I hope you will re-

spond to them—I am sure you will—for the policy but the form it takes must have local input and support.

Mr. BLILEY. Ladies and gentlemen, this concludes our hearing for today. We thank you for your patience with our schedule.

Ms. JONES. Thank you.

Mrs. DRISCOLL. Thank you.

[Whereupon, at 2:55 p.m., the task force was adjourned, to reconvene subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

AUGUST 30, 1983.

DR. WENDY BALDWIN,
Chief, Demographic and Behavioral Sciences, Center for Population Research, National Institute for Child Health and Human Development, National Institutes of Health, Landow Building, Bethesda, Md.

DEAR DR. BALDWIN: This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families' Prevention Strategies Task Force at its hearings, "Teen Parents and Their Children: Issues and Programs," on July 20, 1983. Your participation contributed to making the hearing a success.

The Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

Also, several members have submitted questions and have asked that they be answered for the record:

Congressman Dan Marriott, Ranking Minority Member, Select Committee:

1. Can you cite any research findings on why teens who have become sexually active delay considerably before coming to a family planning clinic? Have there been any studies done that explore the psychological and/or sociological reasons for the delay?

2. What is the relationship, if any, between the age and the time at which a sexually active teenager seeks family planning counseling?

3. There is some indication that a considerable number of sexually active teenagers who initiate contraception subsequently abandon the practice. What are the reasons sexually active teenagers stop using contraception once they have started and are familiar with the procedures?

Are the reasons for stopping medical, sociological, psychological, or a combination of the above?

4. Has there been any research that addresses the changes, if any, in the behavior and decision-making of adolescents in regard to legal authority after they have begun to receive the services of the family planning clinic? That is to say, do the teenagers receiving services tend to become more or less compliant with statutes designed to control teenage behavior in areas such as smoking, drinking and drug use?

Congresswoman Barbara Mikulski, Majority Member of the Task Force:

1. I understand that there has been little research involving young fathers and adolescent males before they become fathers, and that such efforts have been very difficult where they have tried. Are there any new or ongoing investigations to fill that void?

Congressman William Lehman, Chairman of the Task Force:

1. Is there any evidence of differential effects of sex education on teens at different ages?

Congressman George Miller, Chairman, Select Committee on Children, Youth, and Families:

1. Is there any evidence on differences in sexual activity and promiscuity between areas where family planning services, such as those provided by Planned Parenthood, are offered and areas where they are not?

In going over your testimony, you will note members asked for information:

Page 31, Congressman Bliley;

Page 36, Congressman McKernan;

Page 38, Congressman McKernan;

Page 56, Congressman Weiss.

Again, let me express my thanks, and that of the other members of the Committee, for your testimony.

Sincerely,

GEORGE MILLER, *Chairman,*
Select Committee on Children, Youth, and Families.

Enclosure.

QUESTIONS SUBMITTED BY CONGRESSMAN DAN MARRIOTT AND RESPONSES FROM DR. WENDY BALDWIN

1. Questions from Congressman Dan Marriott, Ranking Minority Member, Select Committee:

Can you cite any research findings on why teens who have become sexually active delay considerably before coming to a family planning clinic? Have there been any studies done that explore the psychological and/or sociological reasons for the delay?

Questions about why teens delay have been addressed in a study based on clinic users. Over 1,200 teens were included from many types of clinics. A clinic study is appropriate since it will inform us about the behavior of those who delayed, but who did eventually come to a clinic. Teens offered many reasons for delay. These reasons may be grouped into those reflecting the perception of risk of pregnancy ("I didn't think I had sex often enough to get pregnant") and the barriers to service ("I didn't know where to get birth control"). Three reasons were indicated as the most important: they just did not get around to it; they were afraid that their parents would find out about the visit; and they were waiting for the relationship with the partner to become closer. Fear of a pelvic exam and generalized fears about birth control were also important reasons.

2. Questions from Congressman Dan Marriott, Ranking Minority Member, Select Committee:

What is the relationship, if any, between age and the time at which a sexually active teenager seeks family planning counseling?

One analysis has looked at the risk of pregnancy in the first months following sexual debut and finds that the risk is highest for the youngest teens. This appears to be because these girls (especially those under age 15) are least likely to be contraceptively protected at first intercourse, or soon thereafter. Also, a study of clinic attendees showed that the younger the girl the longer her delay, such that those initiating intercourse at age 13 averaged a 26 month delay and those initiating at ages 18–19 had only a 6 month delay. These data refer to girls who were not pregnant at their first clinic visit and the long delays reflect teenage subfecundity, irregular patterns of sexual activity, and use of non-prescription methods.

3. Questions from Congressman Dan Marriott, Ranking Minority Member, Select Committee:

There is some indication that a considerable number of sexually active teenagers who initiate contraception subsequently abandon the practice. What are the reasons sexually active teenagers stop using contraception once they have started and are familiar with the procedures? Are reasons for stopping medical, sociological, psychological, or a combination of the above?

Teens who had previously had some experience with contraception report that contraception was not used at last intercourse for many reasons, but two stand out: (1) the belief they were not at risk of pregnancy (usually because they believed it was the "wrong time of the month") and (2) the unexpected nature of sexual activity itself. National surveys have found that over half of nonvirgins did not have intercourse in the preceding month. The sporadic nature of sex and the apparent relationship of the intensity of the partner relationship to contraception may lead many girls to discontinue contraception because the relationship with the partner has changed. Contraception is a "problem" for most people given the imperfect nature of all methods, the fact that contraception is associated with an important and affect-laden part of lives and because obtaining and using contraceptives involves not only the person who wants to avoid a pregnancy but the partner and the medical care establishment. The special aspects of adolescent sexual activity serve to exacerbate those difficulties.

4. Question from Congressman Dan Marriott, Ranking Minority Member, Select Committee:

Has there been any research that addresses the changes, if any, in the behavior and decision-making of adolescents in regard to legal authority after they have begun to receive the services of the family planning clinic? That is to say, do the

teenagers receiving services tend to become more or less compliant with statutes designed to control teenage behavior in areas such as smoking, drinking and drug use?

Research relating to early sexual debut, alcohol and/or drug use and smoking finds that these behaviors often appear as a constellation. For example, the adolescent who begins to experiment with cigarettes at an early age is likely to also experiment with other behaviors, including sexual activity. I know of no research that specifically looks at the effects of family planning clinic attendance on drug use or smoking. However, those who begin sexual activity at a young age frequently delay significantly in coming to a clinic, making it unlikely that clinic attendance would influence the other behaviors.

QUESTION SUBMITTED BY CONGRESSWOMAN BARBARA MIKULSKI AND RESPONSE FROM DR. WENDY BALDWIN

5. Question from Congresswoman Barbara A. Mikulski, Majority Member of the Task Force:

I understand that there has been little research involving young fathers and adolescent males before they become fathers, and that such efforts have been very difficult where they have tried. Are there any new or ongoing investigations to fill that void?

There are several projects underway which will increase our knowledge and understanding regarding young males. First, a major national survey is including questions on age of sexual debut, planning of first births, experience with fatherhood and contraceptive information along with extensive information about education, employment, aspirations and abilities. These data will be a significant improvement in our ability to assess the entry of young males into family roles and the consequences of that behavior. Another longitudinal study is offering insights into adolescent sexual behavior for males and females and is focusing on biological changes, influence of parents and peers, as well as addressing the roles of social, educational and economic factors influencing young males' behavior. An in-depth study of families of adolescent mothers shows a deterioration in the relationship with the babies' fathers after the birth. This is consistent with other studies which generally fail to find strong family ties between the adolescent father and mother.

QUESTION SUBMITTED BY CONGRESSMAN WILLIAM LEHMAN AND RESPONSE FROM DR. WENDY BALDWIN

6. Question from Congressman William Lehman, Chairman of the Task Force:

Is there any evidence of differential effects of sex education on teens at different ages?

The research that we have shows that teens who report having had some sex education in schools are no more likely to be sexually active, but if sexually active are more likely to be contraceptively protected at first intercourse. The only age-related effect that I can report on comes from a study at Johns Hopkins which finds that boys are quite receptive to a clinic-based sex education program when in Junior High. By the time they had reached Senior High they were much less interested and did not avail themselves of the services.

QUESTION SUBMITTED BY CONGRESSMAN GEORGE MILLER, CHAIRMAN, AND RESPONSE FROM DR. WENDY BALDWIN

7. Question from Congressman George Miller, Chairman Select Committee on Children, Youth, and Families:

Is there any evidence on differences in sexual activity and promiscuity between areas where family planning services, such as those provided by Planned Parenthood, are offered and areas where they are not?

Research to date has assessed the impact of family planning clinics on pregnancy and birth rates which is appropriate since pregnancy is the behavior that clinics are designed to influence. These analyses show that family planning program enrollment has a depressive effect on the rate of unintended pregnancies and births in subsequent years. The effect on sexual activity cannot be directly measured because there are no data that are specific to small areas. There are inherent difficulties in research of this type. First, areas where there appears to be a "problem" with unintended pregnancies or high rates of sexual activity may be just the communities that begin programs. In that case, sexual and fertility behavior can "cause" program activity although some analyses might make it look as though the opposite occurs. (This is actually a longstanding problem which was observed in Latin American countries where the first women to adopt contraception were those with large

numbers of births, thereby "proving" that contraception caused high fertility.) Data at the individual level can be used to measure sexual activity reported by the teen prior to coming to the clinic and expected level after attendance. However, many teens report that the reason they are coming is that they expect to be more sexually active (a boyfriend may be coming home from school or armed service) or that the relationship with the partner is becoming closer, presumably a factor associated with more sexual activity.

FACULTY OF MEDICINE OF COLUMBIA UNIVERSITY,
New York, N.Y., October 7, 1983.

Hon. GEORGE MILLER,
Chairman, Select Committee on Children, Youth, and Families, House of Representatives, Washington, D.C.

DEAR MR. MILLER: I am writing in response to the Committee's request, for further clarification on the following issues, relevant to my testimony on July 20, 1983 relating to adolescent pregnancy prevention strategies.

Mr. LEHMAN. We have heard that adolescent females under age 15 are at highest risk for poor medical and social outcomes of early pregnancy and parenthood. How has your program been able to address and begin to meet the needs of this seriously at-risk population?

RESPONSE. As I indicated in my testimony, we have had an intensive sex education outreach program in the community over the past six years, that has been developed and supported in cooperation with local schools, parent groups and community organizations. Because pregnancy prevention is our goal, it became clear during this period, that we had to extend these educational efforts to younger age groups and, therefore, much of our work is now done in jr. high as well as elementary schools. Rather than confining our approach solely to factual material on reproductive physiology and contraception, we use an age-specific curriculum in order to cover areas that are relevant to the particular developmental stages of adolescence. For example, we attempt to develop a rapport with older teenagers that allows for discussions relating to values (in particular to those within the socio-cultural context of the Hispanic community), decision-making processes and age-relevant relationships with peers, parents and other adults. On the other hand, work in the elementary schools focuses primarily on body changes and parental relationships, with less direct discussion of reproductive physiology. In addition to these school-based efforts, training programs have been developed to foster parent-teen communication regarding issues of adolescent sexuality and other pertinent topics. Similarly, training programs have been offered on a continual basis to staff of community organizations, and particularly to those that work with younger teens. Despite these concerted efforts, 7 percent of all teens who have sought care at our clinic are less than age fifteen. Given the medical and social risk factors, of which you are aware, we feel that provision of direct clinical preventive contraceptive services must be available to this group, when and if they become sexually active. Notwithstanding our dismay over the fact that very young teenagers are becoming sexually active, and at earlier ages, we believe that there are justifiable reasons for making accessible clinical services available to them. For example, we know that, teenage pregnancy is a prime reason for school dropout and subsequent welfare dependency.

Our profile of female patients under age 15 indicates that 95 percent are still enrolled in school and about one-third come from families receiving public assistance. Nine percent of our patients in this age category had been previously pregnant and thus, they are at even greater risk of a second teen pregnancy. It is also important to note here, that one-third of these patients had been sexually active a year or longer before seeking clinical services. It is important to also note that 55 percent of these patients initiated contact with the clinic for health reasons other than birth control. In sum, we consider this age group the highest of the high-risk and believe that both increased educational and clinic appropriate care be made available to them and their families.

Mr. LEHMAN. Your program focuses heavily on parental and community involvement and support. How are you able to achieve that support? What are its benefits in terms of both preventing teen pregnancy and minimizing the negative consequences for those who do become young parents?

RESPONSE. In addition to the comunity-based efforts cited above, we organized an Adolescent Community Advisory Council before the inception of the program, to guide us in its development and implementation. The Council which has included principals, guidance counselors, community leaders, parents, health professionals and others, has been completely supportive of our approach and work. Given their

continual involvement in its direction and scope, there is no question that while many parents, for example, disapprove of teenage sexual activity, they disapprove even more of a pregnancy. Thus, we feel that developing such a partnership, not only supports the program, but creates a supportive environment for teenagers in the community as well. Teenagers truly need this support in their homes, schools, and comunities, if they are to avoid pregnancy, or to cope suycessfully with parenting, if they chose that option. If we as health professionals in an institutional setting see young people only at that site, we are seeing them in a vacuum.

Mr. MILLER. You have indicated that your program has achieved some significant effects among teenagers in the comunity where you are located. What seem to be the most important factors in achieving that success?

RESPONSE. The most significant quantitive effect we have had on teenagers in our community appears to be the reduction in the percentage of teenage births from 13.8 percent in 1976 to 11.9 percent. Given the devastating consequences of premature parenthood, one can only assume that for every birth averted, we have helped give some young person an opportunity to avail themselves of an education and chose options for a better future. Others have documented the life scenario of the teenage parent. It does not need to be repeated here. We believe that education has played a part, but equally important has been the role of direct service provision that focuses on counseling, as well as clinical contraceptive care.

I would be pleased to answer or expand on any of the above.

Sincerely,

JUDITH E. JONES,
Assistant Director and Assistant Professor of Public Health.

AUGUST 30, 1983.

Ms. ELIZABETH A. MCGEE,
National Child Labor Committee
New York, N.Y.

DEAR MS. MCGEE: This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families' Prevention Strategies Task Force at its hearing, "Teen Parents and Their Children: Issues and Programs," on July 20, 1983. Your participation contributed to making the hearing a success.

The Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

Also, several members have submitted questions and have asked that they be answered for the record:

Congressman Thomas J. Bliley, Jr., Ranking Minority Member of the Task Force:

1. In your testimony you state that one main reason why more young people are getting pregnant is that American families and institutions have failed to help young people make responsible sexual decisions because of what you call a "profound cultural confusion" about what is responsible or moral sexual behavior.

What are your suggestions for reducing the "profound cultural confusion" about what constitutes responsible sexual behavior?

Do you believe that the messages the government sends, through its policies aimed at the problem of adolescent pregnancy, constitute a part of the cultural message being transmitted to adolescents?

Congressman William Lehman, Chairman of the Task Force:

1. You have most recently been involved in a program to promote economic self-sufficiency among teen parents. What strategies seem to be most successful and why? In what ways can those strategies be seen and utilized as primary prevention tools?

2. You have stated that we need to think about approaches to prevent pregnancy that go beyond family planning. From your experience, what kinds of constellation of services seem to be most effective in helping teenagers to prevent pregnancy and to cope with the difficulties associated with pregnancy and parenting if that happens?

Congressman George Miller:

1. You have had more opportunity than most to survey available services around the country. Can you tell us something about how those programs and services are put together and what makes them work?

Again, let me express my thanks, and that of the other members of the Committee, for your testimony.

Sincerely,

GEORGE MILLER, *Chairman,*
Select Committee on Children, Youth, and Families.

Enclosure.

NATIONAL CHILD LABOR COMMITTEE,
New York, N.Y., October 14, 1983.

Hon. GEORGE MILLER,
House of Representatives, Select Committee on Children, Youth, and Families, Washington, D.C.

DEAR CONGRESSMAN MILLER: I am sorry to be so late in responding to your letter of August 30, 1983. Enclosed are by answers to the questions submitted by Congressmen Bliley, Lehman, and yourself in reference to my testimony before the Select Committee on Children, Youth, and Families at its hearing, July 20 1983.

Questions from Congressman Bliley:

We are a pluralistic society. We are also a society whose ideas about the role of sexual expression in the lives of adolescents are in flux. There is no way at this time that we can reach a consensus on some issues such as whether premarital sexual intercourse is moral or not. On the other hand, most American adults do not want teenagers to have babies—unless the young couple is married, finished with vocational preparation, and able to support a baby financially. With leadership, most Americans would support efforts to persuade young people that having a baby before one is ready for parenthood is sexually irresponsible and self-defeating.

For the most part adolescents get their ideas and values about sex from their families, friends, and the media. Of course government policies as reflected in programs such as sex education in schools or family planning services for teens convey certain values. However, since to date the government's efforts to help teens with sexuality have been relatively modest, I think the impact of its messages is limited. Futhermore, I believe the messages government sends through these sorts of programs is generally positive—these programs emphasize being informed about ones choices and making them responsibly.

The scale of government programs to reduce adolescent pregnancy has not been such to reach enough young people. We could do much more to shape the cultural context in which teenagers make decisions. We could help families and youth serving institutions take a more active role in meeting the need of young people for information and adult support. We can do this and still respect the different values about sex that young people and their families hold.

Questions from Congressman Lehman:

Most programs for teen parents focus on young mothers—they are easier to identify and recruit, they have an immediate need for services, they are likely to have custody of their children until they grow up, and given limited resources for services they are seen as having a higher priority for help. Without solid preparation for work many teen mothers will be poor and dependent upon public services for income, housing, food and health care. Special employment assistance programs allow young mothers to work out issues related to being adolescents, parents, and workers simultaneously.

There have been a number of fine projects to help young mothers prepare for work. They offer comprehensive services most of which are located at one site. They provide individualized care through a competent, multidisciplinary team. These projects are carefully structured to make firm demands on participants without being unrealistically rigid. The employment preparation services include basic or remedial education, vocational counseling, and classes that orient young people to work. In addition, a number of model projects provide work experience, skill training, job placement, and support for the young workers on the job.

We do not know the long-term impact of such intervention, but such data as is available suggest that such programs improve the employability of participants. Program participants are more likely to have completed high school and held a job. Also they delay the birth of a second child longer: vocational programs are a form of pregnancy prevention. A service provider trained in health care reported recently, "Now I see that job training for adolescent mothers is a part of family planning!"

We are learning that young men and women would be less likely to accept childbearing as a way to make their lives better if there were more adequate employment opportunities to which they could aspire. In addition to giving young people basic information about sexuality, opportunities to sort out their values about the role of sex in relationships, accessible, attractive clinics where they can get counsel-

ing and birth control services, we must help our children become literate and prepared for work. And when they are ready, there must be decent jobs for them.

Once a teenager has a child, the failure to provide the young couple with comprehensive services contributes to additional pregnancies in the teenage years, neglect of children by their fathers, poverty, welfare dependency, and other self-destructive behavior to which people resort out of depression and hopelessness.

Questions from Congressman Miller:

Comprehensive services that are part of an integrated service delivery system, at as few sites as possible, provided by competent and compassionate multidisciplinary staff and that have a strong employment preparation component are the most effective way to help teenage parents. While many of these service models could be further refined, we have adequate information about successful approaches to significantly reduce the problems associated with teenage parenthood. We now need the will and funding to offer services to teenage parents on the scale that is necessary.

I hope this is useful for you.

Sincerely,

ELIZABETH A. MCGEE, *Project Director,*
Economic Self-sufficiency for Teenage Parents.

AUGUST 30, 1983.

Dr. EFFIE ELLIS,
North State Street, Apt. 4605,
Chicago, Ill.

DEAR DR. ELLIS: Following up my letter of August 24, sending along a copy of your testimony before the Prevention Strategies Task Force for editing, I would appreciate a little more of your time.

Congressman William Lehman, Chairman of the Task Force, Congresswoman Barbara Mikulski and I have a few questions we would like to have answered for the record:

Mr. LEHMAN. Can you elaborate on your formal remarks regarding why it is so important to take into account the community and larger ecological context in dealing with the problems of teen pregnancy and parenthood?

Ms. MIKULSKI. It has only been recently that we have begun to focus attention on young men and young fathers. As you have indicated and we all know, they are at least half the problem and certainly must be part of the solution. What are the chief barriers to the involvement of young men in primary prevention programs? How can we most effectively encourage the development of a greater degree of awareness and responsible action by young males?

Mr. MILLER. Given your wealth of experience as a physician and concerned citizen in this area, what do you see as the biggest problem generally in early pregnancy prevention, and specifically in communities where the rates of teen pregnancy and early child bearing are highest?

Once again, your testimony has been important to the Committee and your help is greatly appreciated.

Sincerely,

GEORGE MILLER, *Chairman,*
Select Committee on Children, Youth, and Families.

SEPTEMBER 28, 1983.

Congressman GEORGE MILLER,
Chairman, Select Committee on Children, Youth and Families, House of Representatives, Washington, D.C.

DEAR CONGRESSMAN MILLER: Enclosed, please find answers to questions raised by Congressman Lehman, Congresswoman Mikulski and yourself for the record.

Please let me apologize for the delay in getting this material back to you. A number of unforeseen events made it impossible for me to send it on to you at an earlier time.

If I can be of any further assistance to the Committee, please feel free to contact me.

Sincerely,

EFFIE O. ELLIS, M.D.,
Consultant.

TESTIMONY OF EFFIE O. ELLIS, M.D., PREVENTION STRATEGIES TASK FORCE

Question: Mr. Lehman

Can you elaborate on your formal remarks regarding why it is so important to take into account the community and larger ecological context in dealing with the problems of teen pregnancy and parenthood?

Answer: Dr. Effie O. Ellis

Within the family and the community are found the supportive services that determine outcome of pregnancy and parenting. There are wide variations in the degree of maturity, attitudes and life experiences of adolescent girls. Yet each expectant mother or parent must respond to the challenges of the various environments in which they live, learn and work.

If we wish to make progress in the prevention of adolescent pregnancy and parenthood, the needs of the adolescent, as a developing person, must be considered and met within the environmental framework. The people and institutions that make up the various environments.

Question: Ms. Mikulski

It has only been recently that we have begun to focus attention on young men and young fathers. As you have indicated and we all know, they are at least half the problem and certainly must be part of the solution. What are the chief barriers to the involvement of young men in primary prevention programs? How can we most effectively encourage the development of a greater degree of awareness and responsible action by young males?

Answer: Dr. Effie O. Ellis

There are several barriers to involvement of young men in prevention.

1. Our society is not geared to recognize and address, comprehensively, the growth and developmental needs of adolescent males. The community institutions do not involve adolescent males in serious issues relating to the quality of their lives. What is more disturbing is the fact that males receive less preparation for adolescence than females, and the latter is very limited. In most instances, neither the schools nor the private agencies have developed effective programs, including male sexuality.

2. There is lack of knowledge, and communication skills within the home. Far too many parents and uncomfortable with their own sexuality. Therefore, they are unable to meaningfully discuss the subject with their children. Unfortunately, there is little help in most communities to assist parents in learning how to parent adolescents.

3. The media and idols of teens have not said, "it's all right" to be involved in prevention. In addition, peer pressure is strong for one to be macho.

4. Increasing numbers of teens suffer from a poor sense of self worth and low self esteem. It is difficult, if not impossible, for this group to make the simple acknowledgement that there is something about their bodies that they don't know. To admit their ignorance about themselves or sex only increases their frustration that is characteristic of this turbulent period.

Now, let's look at the other side of the coin. Development of increased awareness of the problem and growth toward responsible action by males requires a total societal effort. Such an effort should include:

1. Ongoing parent education. Many parents do not understand the tasks and needs of the adolescent. Neither do they have the specific knowledge about adolescent sexuality. Education is necessary to help parents remain in charge and able to make adequate decisions.

2. Special effort by the schools to carry out effective and meaningful programs. Total growth and developmental needs with a sharp focus on sexuality should begin, at the latest in 5th grade. Teachers must be carefully selected, specially trained and sensitized to do this work.

3. Reinforcement activities carried out by community organizations can play an important part in addressing the concept of self and personal worth. Vehicles such as retreats, seminars and planned extracurricular activities can be helpful.

4. The development and implementation of public relations campaign that "frees" teen males to acknowledge teen pregnancy as an important issue. Focus should be squarely placed on how males should address the problem.

Question: Mr. Miller

Given your wealth of experience as a physician and concerned citizen in this area, what do you see as the biggest problem generally in early pregnancy prevention,

and specifically in communities where the rates of teen pregnancy and early child bearing are highest?

Answer: Dr. Effie O. Ellis

I believe that the biggest problem in the highest risk communities is the break down of family. The family unit is the foundation of what we become. For black people it has been the extended family that has brought us through.

In the black communities, the black single parent families lead to alienation between teen males and adult males. Thus the framework for orderly growth and development is weakened. Thus, outreach to the family in order to help develop a supportive environment for the young child is of highest importance.

The supportive services should be as complete and intense as necessary to strengthen and maintain the family.

Parents, girls and boys should be given the education and medical advice they need to prevent children from having children.

[From the New York Times, Mar. 13, 1983]

To Fight Teen-Age Pregnancy

(By Eunice Kennedy Shriver)

WASHINGTON.—Old ideas never die. Unlike old soldiers, they don't even fade away. It is in the service of an old idea that two Federal district judges have ruled against a regulation that Government-funded family-planning clinics notify parents of teen-agers who obtain prescription contraceptives.

In Manhattan, Judge Henry F. Werker based his ruling on an interpretation of what Congress intended under Title X of the Health Service Act, which encouraged, but did not make mandatory, family involvement in family-planning services for adolescents. In Washington, in a separate decision based entirely on Congressional intent, Judge Thomas A. Flannery also struck down the notification restrictions. But in 1981, Congress amended the Health Service act further in the family life amendments (Title XX), in which Congress insisted on family involvement in the sexual decision-making of minor children. Accordingly, I think the judges' interpretations of Congressional intent are too narrow.

In Title XX, Congress clearly recognized that the growing problem of adolescent pregnancy cannot be solved by the secret and wholesale distribution of contraceptives, but that services encouraged by the Government "should promote the involvement of parents with their adolescent children." What could be more explicit an expression of intent than this? If Congress had wanted to create just another system for delivering contraceptives to adolescents, it would have put more millions into family planning under Title X. But it did not.

Adolescent family life legislation obviously was intended to differentiate between services to teen-agers and to adults, to help young people understand their sexuality, to encourage them to recognize the seriousness of starting a family, to teach responsibility and to underscore the need for communication and openness between parents and children.

Conferring adult status on children 13, 14 and 15 years old by substituting professional intervention for family involvement has been a failure in such critical areas of adolescent conduct as drug and alcohol abuse. It has not worked and Congress did not intend to perpetuate it.

For years, family-planning agencies have secretly handed out contraceptives, and the rate of adolescent pregnancy has not significantly declined. Tragically, it has increased among girls under 15, who most need parental involvement in learning to deal with awakening sexuality.

Working in the field of adolescent pregnancy for more than a decade, I have spoken to hundreds of pregnant adolescents. The chief reason that teen-agers become pregnant is not that they lack access to contraception, but, as one 15-year-old said: "I'm pregnant because I want to be pregnant. I could have controlled it. I wanted a baby so I could love it and just make me feel good."

These young women engage in sex not out of grand passion but because of emotional problems, school problems, peer pressure, and trouble at home. What they need most is the support and encouragement of their families, churches, community institutions—not official sanction to keep their problems hidden from their families.

In Title XX, communities were challenged to develop family-centered programs. In St. Paul, Minn., teen-agers get the chance to care for infants and young children at a day-care program so that they can gain an appreciation of parental responsibil-

ities. In demonstration programs in Albany, N.Y., Tacoma, Wash., Elkins, W. Va., and Dorchester, Mass., parents attend training sessions with their teen-age sons and daughters. In adolescent pregnancy programs such as the one at Johns Hopkins Hospital in Baltimore, research shows that when families become involved in their pregnant teen-agers' lives, the young women are more likely to stay in school, remain off welfare, get a job, develop a more positive self-image and take better care of their babies, and that they are less likely to have an early repeat pregnancy.

If this family support works with pregnant adolescents, why shouldn't it work for those not yet pregnant?

I challenge those who interpret our laws and regulations to recognize that Congress clearly intended that families be involved in decisions concerning their children's health and safety. I challenge professional family-planning agencies to reject the old idea that pregnancy can be treated only by private decisions for contraception, sterilization or abortion. I urge them to try developing new approaches to prevention of adolescent pregnancy based not on secrecy but on trust, openness, strengthening of families.

With or without the regulations that the courts have temporarily suspended, let us concentrate on positive family values and build on them instead of alienating the family from the most difficult of life's decisions and trying to solve problems with a pill.

[From the Washington Times, Apr. 26, 1983]

TEACHING GIRLS TO SAY "NO"

(By Eliza Paschall)

Planned Parenthood of Atlanta, along with 26 other private and public health and youth service agencies, is sponsoring a program to persuade 16-year-olds and younger teen-agers that "you ought not to be having sex at a young age" and to encourage parents to talk with their sons and daughters "about your religion, your beliefs, your values, your feelings."

The Campaign for Responsible Parenthood and its education series for "Postponing Sexual Involvement" is a program of the Teen Services of metropolitan Atlanta's large public Grady Memorial Hospital. Dr. Marion Howard, director of Grady's Teen Services Program and associate professor in Emory University's Medical School Department of Gynecology and Obstetrics, says it is a response to several facts:

1. One out of every eight girls in Georgia, including Atlanta, becomes pregnant while still under 18.

2. Atlanta's public schools for the past six years have had a sound sex program for the eighth grade.

3. Grady for the past 12 years has provided birth control information and services to teen-agers in metropolitan Atlanta.

4. Many psychologists theorize that it is very likely that under-18-year-olds have not developed the ability "to move from concrete to operational thinking, i.e., the ability to weigh alternatives and consequences and therefore to make choices based on ability to conceive in the future."

5. Present sex education and support systems are designed to support and encourage those who are sexually active and those who do become pregnant, not those who choose to postpone sexual involvement and choose not to become pregnant.

The sum total of these facts, the doctor says, is that the expectation that knowledge about sex and the availability of contraceptives will control teen-age pregnancy has proved to be false. "The commonly proposed solutions to teen pregnancy (sex education and birth control) are already in place in Atlanta and are having whatever impact they can have . . . they are not sufficient in dealing with the problem."

Acknowledging that these solutions were not sufficient, Howard and her staff went to the Atlanta community to find out if the community was aware of the teen pregnancy rate; if the community perceived that to be a problem; what focus did the community want in programs dealing with the subject. They found out that yes, the community was aware; yes, the community does perceive it as a problem and it wanted a program involving parents and focusing on postponing sexual involvement.

The Coalition for Responsible Parenthood headed by Mayor and Mrs. Andrew Young sponsored the "Let's Talk" series involving parents and teen-agers, and out

of that grew a second series on "Postponing Sexual Involvement," more popularly known as the series to "Learn How to Say 'No.' "

Both series differ distinctly from other efforts to deal with teen-age pregnancy in two ways. The curriculum starts with a given value: "You ought not to be having sex at a young age." Every thing is designed to reinforce that predetermined goal. Other sex education programs present alternatives to teen-agers, with the hope they will act responsibly. "This series, 'How to Say No.' avoids the double message implicit in such programs."

The second unique feature is that the exercises are designed to have the participants in discussion groups, role playing, etc., experience social success while saying "no" to sexual involvement. Participants are not permitted to decide how their "role" shall be played. It is to be played so that "it comes out all right for the person saying 'no,' the girl doesn't lose her boyfriend, the boy isn't called "gay," both stay popular. . . .

Parental responses to the programs has been unusually high. The programs can strengthen the resolve of teen-agers who have decided to postpone sex and also can support the parents in their support of the teen-agers. "It is our feeling," Howard says, "that teens who decide not to have sex get little support and few rewards from agencies and others for their behavior."

The doctor has no compunctions about using the word "ought" and no apologies for taking a position in favor of postponing sexual involvement. The "Lets Talk" brochure prepared for mailing to parents of all teen-agers in the Atlanta schools says "Saying 'no' is the only 100 percent sure way of preventing pregnancy and VD. . . . Some diseases spread by sexual contact can't be cured. More and more grownups are finding they can't have a baby because of infections got from teen sexual activity. . . . Girls and boys who become parents while teens may not finish school and may not be able to get a good job, may hurt or not take good care of their child, may have to be on welfare, may not have healthy babies."

We know the bad effects of early sex. We know the effects of smoking, but millions still smoke, Howard explains. Knowledge alone does not change behavior. Behavior reflects values. Postponing sexual involvement is a community value in Atlanta. The "Postponing Sexual Involvement" series is institutionalizing that value and making it easier to uphold.

Atlanta is not alone in rethinking its message to teen-agers about sex, judging from the interest all over the nation in these programs. A recent article in the publication of SIECUS (Sex Information and Education Council of the United States) describing the Grady programs has generated much interest. Both the "Let's Talk" and "How to Say 'No'" series are being packaged for adaptation to other communities and can be obtained from the Teen Services Program Grady Hospital, Atlanta.

The Atlanta experience is a refreshing instance of professional integrity. Howard and her associates, like their colleagues, has certain theories about teen-age pregnancy. The theories were tested and found wanting. Instead of focusing on defending the theories, they are focusing on other theories to test.

Howard has a theory that young teen-agers are called on to make decisions about sex whereas decisions in areas less important, or certainly no more important, are made for them. In sex education classes, she says, a teen-ager often will ask "Should I become sexually involved?" and is told "It depends on how you feel."

If the same young teen-ager had asked "Should I drink alcohol, should I drive a car, should I vote?" we wouldn't say "It depends on how you feel." Why should decisions about sex be so different.

[From the Washington Post, Jan. 16, 1982]

"No, It's Morally Wrong"

(By Colman McCarthy)

As teachers of reproduction, the Planned Parenthood Federation of America has few peers. As counselors in sexuality, it has new ideas.

Nowhere is the difference better seen than in "Teensex? It's Okay to Say no way." Last week the federation announced that the pamphlet has become a "best-seller," with 1.5 million copies distributed since publication in 1979.

No one can quarrel with the pamphlet's effort to "allay the hesitation and fear some teen-agers feel about saying 'no'" to sex. And no one can deny that the high rates of teen-age pregnancy, abortion and venereal disease have created a chaos in

which it appears, as one social observer noted. "Our biological drives are several million years older than our intelligence."

The intellectual failure of Planned Parenthood is that it provides no moral context for the discussion. The ethical teachings of history's moral leaders on promiscuity are ignored. Instead, teen-agers are spoken to in pitter-pat. The federation counsels them not to be taken in by the line "C'mon, everybody's doing it." They are told the only question is: What's right for you?" They are advised that sex won't cure loneliness, prove independence or increase popularity.

But they aren't given moral guidance—that sexual looseness violates moral codes representing the collective integrity that has endured throughout history. They aren't told that chastity and abstinence for adolescents are values honored in all the world's major religions.

That groups like Planned Parenthood avoid the moral context of human sexuality is an easy out: the kids might call us prudes, they might tell us to peddle our Victorian hangups elsewhere.

Such hesitation vanishes when we tell the young that it is morally wrong to shoplift, to take drugs or to cheat in school.

Schools and public service agencies that don't hesitate to impart these value-laden strictures lose their nerve in sexual education. Some schools see themselves as forward-thinking merely to be giving courses in sexual technology. Others go further and join the Planned Parenthood effort to provide value-free counseling.

But it's not enough. It leaves the young floating free. One way or an other, they are being sexually educated all the time—at the magazine rack, by films and television, by advertisements that depict Joe Namath or Brooke Shields hawking suggestiveness.

With human sexuality being "taught" in this kind of cultural explosion, the chances increase that the young will make sexual decisions based on ignorance. If a group like Planned Parenthood, which puts itself forward as an "advocate of reproductive rights for everyone," is tepid about discussing moral codes, the young are that much more vulnerable to reactionary moralizers at the other extreme. These are the book-banners and finger-pointers who in their Thou-Shalt-Not crusades offer nothing more than railing against America the New Sodom and Gomorrah.

Caught in the middle and supported by neither the pamphleteers of Planned Parenthood nor the New Puritans passing their "family life" laws, are educators like Mary Lee Tatum. For the past nine years, she has been teaching a seminar in human sexuality within a value framework at George Mason High School in Falls Church. "The students really want to talk about morals and values," she says. "They are eager to discuss why they do things and the consequences of their behavior, romantic and sexual. In the classroom, I try to create an excitement about developing one's values.

Every high school in the country should have a teacher like Mary Lee Tatum. She understands that a moral perspective is as needed a form of prevention against unwanted pregnancy and venereal disease as a knowledge of birth control, fertility and anatomy.

For the unmarried young, it's okay to say "no, it's morally wrong."

[From the Washington Post, Apr. 24, 1983]

Squealing Won't Do Any Good: But Parents Need Government's Help In Influencing Sexual Attitudes

(By Morton M. Kondracke)

Once upon a time, when I was a young liberal and my daughters were babies, I scorned the kind of narrow-minded, punitive Puritanism that led the Reagan administration to decree its so-called "squeal rule"—the one requiring parental notification when teen-agers seek contraceptives from government-supported agencies.

That was yesterday. Today I am the aging father of adolescent daughters and I understand the Reaganites' attitudes better. It is not, as I once would have thought, that they want to resurrect Victorian values by using pregnancy as the punishment for sex.

Rather, the squeal rule arises out of an impulse to strengthen the tattered fabric of family life in the intimate matter of sexual mores. Parental credibility in counseling "don't" is being ripped to shreds by television, movies, magazines and records that blare out the consistent message: "Do it!" "Everybody does it." "Even nice girls do it."

With so much salesmanship behind it (not to mention peer pressure and natural urges), the message is getting through. About half of all girls under 17 and 56 percent of boys are sexually active. Those percentages grow larger every year while the average age of first sexual involvement gets lower. It's now 15.7 years for boys, 16.2 for girls.

Any responsible parent has to view those trends with alarm. Sex is a grownup activity involving the most serious of life's consequences—intense emotional commitment, the possibility of birth and the possibility of death. The child who has taken up sex inevitably has moved away from his or her parents. Every year, parents are losing their children at a younger and younger age.

Along with the Reaganites, I abhor the Playboy magazine logic accepted by many liberals: face it, Dad, kids are into sex and the best thing to do is teach them how to do it responsibly.

Sorry, the responsible things for a 15- or 16-year-old to be doing are running track and learning math. Somehow, society—and certainly, the government—ought to help parents to help their kids avoid sex before its time.

For all these reasons, I sympathize with the motivations behind the "squeal rule," but I still oppose it. It simply won't accomplish its intended result. It will just get girls pregnant. Right now, the rule is under court injunction, barred from taking effect nationally. An appeals court is to fuel on it sometime this spring and probably the loser (the Reagan administration or Planned Parenthood) will take the case to the Supreme Court. The administration would do better by withdrawing the rule and trying something different.

The Reaganites obviously hope that when a letter arrives advising parents that their daughter has applied for contraceptives, a reasoned, compassionate family discussion will ensure, leading to a decision that daughter should wait.

The problem is that, in the vast majority of cases, the issue of waiting or not waiting is long over by the time girls go to the family planning clinic. Surveys taken at family planning clinics show that only 14 percent of girls seek contraceptives before having sex for the first time. On the average, the clients have been sexually active for nearly a year, often without benefit of birth control.

I am not bothered at all by the alleged sex discrimination implicit in the squeal rule—the fact that it affects girls and not boys (who can get their contraceptives at the drug store, no questions asked). If the Reagan rule worked, parental notification would prevent pregnancies, and it is girls who get pregnant, not boys

But the rule will not work and it does discriminate against poor girls who cannot afford to see a private gynecologist and get a confidential prescription.

Poor families are less inclined than better-educated ones to have the reasoned, compassionate discussion the Reaganites hope will follow parental notification. Poor kids tend to get involved in sex earlier than wealthier ones, to be less informed about birth control and to produce more babies out of wedlock. The Reaganites want to cut back on AFDC, but the squeal rule only swells the number of potential recipients.

Poor or rich, the girl who thinks she can tell her parents she is going for birth control will tell them, and parental notification won't be needed. The girl who can't tell her parents—who fear their knowing—may well be discouraged from going to a clinic.

The administration claims the squeal rule will cut clinic caseloads by only 4 percent. That seems a ridiculous underestimate. Planned Parenthood asserts the correct figure is 25 percent. Either way, though, its certain that the rule will increase the number of teen-age pregnancies, abortions and unwanted babies. There already are too many of all three.

Parents do need the government's help in influencing the sexual attitudes and behavior of their children, but the time for exerting influence is long before they arrive at the door of the birth-control clinic.

The Reagan administration should withdraw the squeal rule and devise programs to educate parents on how to talk to their children about sex and values. And it might help, too, if President Reagan would speak to his friends in Hollywood about the extent to which they have oversexed American society.

Family Planning Clinics: Cure or Cause of [redacted] Pregnancy?

Michael Schwartz and James H. Ford, M.D.

The co-authors of this article were recipients of the Linacre Quarterly *award for their article in the February, 1979 issue entitled "Birth Control for Teenagers: Diagram for Disaster."*

During the March, 1981 hearings on the extension of Title X family planning funding, Faye Wattleton, president of the Planned Parenthood Federation of America, told a Senate subcommittee that "the success of the national family planning program is stunning: . . . because of increased and more consistent use of contraception, the pregnancy rate among sexually-active teenagers has been declining."[1]

The most "stunning" aspect of this assertion is that Ms. Wattleton had the nerve to make it. The actual change in the rate and number of premarital teenage pregnancies since federally-funded programs were enacted to "solve" the social problem of teenage pregnancy offers stunning evidence that these programs have been a colossal failure. The number of out-of-wedlock births to teenage mothers increased from about 190,000 in 1970 to about 240,000 in 1978. The birth rate among unmarried teenagers showed a similar increase, from 22 per thousand to 27 per thousand. These recorded live births are just the tip of an iceberg. Abortions among teenagers increased fivefold in less than a decade from perhaps 90,000 in 1970 to almost half a million by 1978. The total annual number of premarital pregnancies more than doubled during this time span, from about 300,000 to about 700,000. In light of these alarming statistics, one must conclude either that Ms. Wattleton does not know what she is talking about, or that she is deliberately fudging on the figures in order to protect a federal program which her organization has aggressively promoted and from which it receives a great deal of money.

To assume the first hypothesis, that Ms. Wattleton is honest but misinformed, one must believe that she neglected to look at the September/October, 1980 issue of *Family Planning Perspectives*, the magazine published by the organization over which she presides. The lead editorial in that issue opens with the admission that "more teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital adolescent pregnancies continues to rise."[2]

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That same issue of *Family Planning Perspectives* carried the initial report on the third national survey of teenage sexual activity, contraceptive use and pregnancy, undertaken in 1979 by Professors John F. Kantner and Melvin Zelnik of Johns Hopkins University.[3] This study was similar to surveys conducted by the same researchers in 1971 and 1976.

The 1979 data were drawn only from teenagers living in metropolitan areas, so they are not exactly comparable with the previously published statistics from the 1971 and 1976 surveys. But in order to make valid comparisons and to show trends, Kantner and Zelnik separated from their earlier studies the data for metropolitan-area teenagers, and presented those figures along with their more recent findings.

The most notable trend observed by Kantner and Zelnik is that the proportion of metropolitan-area teenagers who reported having at least one premarital pregnancy increased steadily, from 8.5% in 1971 to 13% in 1976 to 16.2% in 1979.[4] Thus, in the first eight years of the operation of Title X programs, the percentage of teenagers experiencing a premarital pregnancy almost doubled. In this respect, Kantner and Zelnik's observations are in agreement with those of the Census Bureau.

The obvious cause for this increase, as documented in the same survey, has been the continuing rise in the percentage of teenagers who engage in premarital intercourse. Among the metropolitan-area teenage women surveyed, this percentage increased from about 30% in 1971 to about 50% in 1979.[5]

In a previous article based on the first two Kantner-Zelnik studies, we demonstrated that the increased use of contraceptives among teenagers does not lead to a reduction in the rate of out-of-wedlock teenage pregnancy.[6] One reason for this is the notoriously high rate of contraceptive failure among teenage users. Another is the fact that the availability of contraceptives contributes to an increased exposure to the risk of pregnancy by stimulating an increase in the percentage of teenagers who are sexually active and an increase in the frequency of intercourse among those who are sexually active.

The results of the latest Kantner-Zelnik survey bear out these observations with even greater force than previously.

The False Promise of Contraceptive Protection

As noted in numerous Planned Parenthood sources, the use of contraceptives among unmarried teenagers improved dramatically during the 1970's. Among the more than 4,000 young women interviewed in Kantner and Zelnik's 1971 study, just over a quarter of those who had never been married (26.8%) had experienced premarital intercourse.[7] Of these, only 18.4% reported using a contraceptive on every sexual encounter, while a nearly equal number (17%) had never

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used contraception. Perhaps a more telling figure is that fewer than half the young women who had ever experienced premarital intercourse (45.4%) had used a contraceptive at their last sexual encounter.[8]

Among those who had ever used contraception, the single method that had been used by the highest number of respondents (64.3%) was also one of the least effective, withdrawal. Condoms ranked close behind among methods ever used, with 60.6% of the respondents having used them. Oral contraceptives, considered the most effective and most sophisticated contraceptive technique, ranked a distant fourth among methods ever used, with only 26.9% of the contraceptive users reporting use of this method.[9] That means that out of an estimated 2.3 million sexually-experienced unmarried teenage women in 1971, fewer than 500,000 had ever used birth control pills.

The relative sophistication of contraceptive techniques among unmarried teenage women can be more realistically assessed by an inquiry into the method most recently used among the 1971 survey respondents. The condom (32.1%) and withdrawal (30.7%) were the two most common methods, but oral contraceptives were not far behind at 23.8%.[10]

The contraceptive use situation among unmarried teenagers in 1971, then, could be summarized by saying that most teenagers with premarital sexual experience had used contraception, but they had not done so consistently and they tended to use relatively primitive, ineffective methods. It is also worth noting, although not at all surprising, that contraceptive use among those over the age of 18 was superior to that among 15 to 17 year olds in terms of both consistency of use and sophistication of method.

Kantner and Zelnik estimated that 1,135,000 15 to 17 year olds were sexually experienced.[11] About 20% of them had never used a contraceptive, exceeding the number who had always used contraception, and fewer than 40% had used a contraceptive at their last intercourse. Among these younger teenagers, only 17.4% of those who had ever used any method had ever used the pill, a rate that was less than half that of pill use among 18 and 19 year old contraceptive users, so that fewer than one-third of all unmarried teenage pill users were under 18.[12] In addition, among all teenagers using contraception, fewer than one in 10 had obtained services from a non-hospital birth control clinic.[13] This represents the status of contraceptive use among teenagers about the time federal funding for birth control services for unmarried minors began.

By 1976, the date of the second Kantner and Zelnik survey and five years after the implementation of federal funding of birth control clinics for teenagers, the situation had changed dramatically. First, the incidence of premarital sexual activity among teenage women had increased markedly, climbing by nearly one-third in just five years. By 1976, the percentage of never-married teenagers who had experienced

premarital intercourse was almost 35%, and this increase in sexual activity was most pronounced among those under 18. [14]

Yet, with the increase in premarital sexual activity among teenagers, there had also been a significant improvement in contraceptive use. Among those who were sexually experienced, no fewer than 30% were always-users of contraception, [15] a proportion two-thirds higher than five years before. In absolute numbers, more than twice as many young women were regular users of contraception in 1976 than in 1971. However, the proportion of never-users of contraception among those who were sexually experienced had also increased to 25.6%. [16]

The increased proportion of never-users may not be as great as it looks, for one-seventh of all those respondents who were classified as sexually active had intercourse only one time, [17] and slightly more than half of those did not use contraception on that occasion. If all those who had intercourse only once are left out of consideration, the proportion of sexually-active teenagers who never used contraception is only about one in five while the always-users remain near 30%. Unfortunately, it is not possible to compare these rates with those found in 1971 because the 1971 survey did not determine how many of those categorized as "sexually active" had had intercourse only one time. This information does show, however, that the increase in the proportion of teenagers who engaged in sexual relations without using contraception was not as pronounced as the increase in those who always used contraception.

Furthermore, in spite of the increased percentage of never-users, a solid majority of 63.5% of all those with premarital sexual experience — and more than two-thirds of those who had intercourse more than once — had used a contraceptive at their last sexual encounter. [18] Moreover, this increase in last-time use of contraception, while it was present in every age bracket, was most pronounced among those under 18. In fact, more respondents in the 15 to 17 age group in 1976 had used a contraceptive last time than had 18 and 19 year old respondents to the 1971 survey. [19] It is clear, then, that far more teenagers in 1976 were using contraception and using it more consistently than were teenagers five years before.

At least as significant as the increased regularity of contraceptive use was the increased sophistication in contraceptive methods. By 1976, oral contraception had far outstripped all other methods in popularity among unmarried teenagers, having been used by 58.8% of all unmarried teenage contraceptive users. Condoms had been used by less than 40% and withdrawal, formerly the most commonly used method, declined to 30%, half its 1971 rate. [20] Among survey respondents under the age of 18, the proportion which had used oral contraception increased by more than 250%.

The improvement in contraceptive use among unmarried teenagers is even more graphically illustrated in a survey of the most recently

used methods. Oral contraception among teenage contraceptive users had doubled in five years, from 23.8% to 47.3%, and more than half of the teenage contraceptive users were using the pill or the IUD by 1976, while only one-fourth had been using these medical methods in 1971.[21] Even among younger teenagers, the pill had become the most popular method of contraception. Kantner and Zelnik noted that the use of medical methods of contraception among unmarried teenagers in 1976 was at an even higher rate than that found among married women of reproductive age in 1973.[22] Almost half the teenage pill users in 1976 had obtained their first prescription from a clinic, so there can be no doubt that this sudden and massive shift in contraceptive patterns among unmarried teenagers was primarily a result of the organized family planning programs that were set up in the early '70s.[23]

Preliminary data from the most recent survey by Kantner and Zelnik in 1979 indicated a slight decline in the proportion of teenage contraceptive users who had used the pill as their most recent method, from 47% to just over 40%.[24] This, however, must be balanced against the continuing steady increase in the proportion of teenagers who have had premarital intercourse — up by about an additional 15% in three years and the increasing proportion of those who had ever used contraception and those who always used contraception. The data published so far from the 1979 survey includes only teenagers in metropolitan areas, so they must be compared with only the metropolitan-area portions of the previous surveys. However, they show a decline in the proportion of never-users of contraception, down by about one-fourth and an increase in the proportion of always-users, by about one-fifth. This means that the mere proportional increase in the use of contraception among unmarried teenagers is sufficient to compensate for the relative decline of the pill as a method of choice.[25] Meanwhile, the overall growth in the number and percentage of all teenagers who have premarital sexual experience has stimulated a continued increase in the absolute number of teenagers on the pill.

The information from the 1979 survey, partial and preliminary though it is, suggests that the increase in contraceptive practice among unmarried teenagers is tapering off. This is probably because the saturation point has been reached. It would be unrealistic to expect contraceptive use patterns significantly better than those reported in 1976 and 1979 — at least without the use of coercion which, odious as it may seem, has been seriously proposed by some population control advocates[26]—especially when it appears that high school girls today are about as conscientious and as sophisticated in the use of contraception as their mothers are.

At this point, the only factor that can significantly contribute to an absolute increase in contraceptive use among teenagers is a continued increase in the proportion of teenagers who are sexually active. This, as we have seen, was already the case between 1976 and 1979. During

that period there would have been no major increase in the number of teenagers using contraception except for the fact that a greater proportion had experienced premarital intercourse, and hence were potential contraceptive users. As the total teenage population declines, the importance of this factor in determining the size of the market for contraception will become increasingly apparent. That population decline is already well underway. From an all-time high of 10.7 million in 1976, the female population in the 15 to 19 age group is already below ten million and will be down to only eight million by 1990.

Notwithstanding the sudden and dramatic increase in the frequency, regularity and sophistication of contraceptive use among teenagers — which must surely rank as one of the most significant social changes ever wrought by government policy — the rate of out-of-wedlock pregnancy among teenagers showed its most alarming increase in history. Moreover, the pregnancy rate among contraceptive users grew just as rapidly as that among non-users.

By 1976, 10.9% of the always-users of contraception had experienced at least one premarital pregnancy — a rate almost as high as that reported among the entire survey population (11.6%) and considerably higher than the rate of unintended pregnancies among the entire survey population (8.3%).[27] But it appears from the data published in connection with Kantner and Zelnik's 1979 survey, that metropolitan-area teenagers, while displaying a higher rate of premarital sexual activity and pregnancy, are more effective contraceptive users than their non-metropolitan sisters. A total of 13% of the metropolitan teenage women surveyed in 1976 had experienced a premarital pregnancy, but only 9.9% of the always-users of contraception among them had been premaritally pregnant. By 1979, 16.2% of all metropolitan teenage women, and 13.5% of the always-users among them, had experienced a premarital pregnancy.[28] If the intended pregnancies among these young women are discounted, the rates of pregnancy among always-users and the rest of the teenage population are nearly identical and, in both cases, climbing rapidly.

The most tangible result, therefore, of the dramatic improvement in contraceptive use among teenagers which has been effected by the Title X family planning programs has been that a higher proportion of premarital teenage pregnancies occurs among contraceptive users. Always-users of contraception accounted for 14% of all premarital teenage pregnancies in 1979, and for more than one-sixth of the unintended pregnancies. Almost one-third (31.5%) of the unintended pregnancies among metropolitan-area teenagers in 1979 occurred while a contraceptive method was in use — a proportion almost four times as high as the 1971 figure of 8.6%. And nearly half the unintended premarital pregnancies among 1979 survey respondents (49.7%) occurred among young women who had used a contraceptive at some time.[29]

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Perhaps the officers of the Planned Parenthood Foundation can take pride in these statistics, for they are manifest evidence that more teenagers than ever before are using contraception. If the tactical goal of family planning providers is to persuade young people to use contraception, no one can deny that they have been remarkably successful. At the same time, one may legitimately question whether the results obtained from these programs are really what Congress had in mind when it established federally-funded family planning services. In any case, these figures do make it unreasonable to claim that the provision of contraceptives to minors actually reduces the incidence of teenage pregnancy.

Yet, this is not the claim which Wattleton made in her Senate testimony. She deliberately left out of account the real cause for the drastic increase in the rate of premarital teenage pregnancies; namely, the equally-drastic increase in the proportion of teenagers who were sexually active. She contented herself with the far more modest claim that the pregnancy rate among sexually-active teenagers had declined.

Even if this were true, it would not offer a valid measurement of the effectiveness of the birth control programs. Even if the pregnancy rate among sexually-active teenagers had remained unchanged, the increase in the number and proportion of teenagers who were sexually active would, in itself, have accounted for an equivalent increase in the overall rate of premarital teenage pregnancies, and it is this rate which the programs are ostensibly aimed at reducing.

Moreover, it is to be noted that a measurement of the pregnancy rate only among those teenagers who are sexually active, while it is worthless in assessing the success or failure of those programs, does cast the most favorable possible light on the birth control programs. The direct result of the programs has been to stimulate more widespread, more regular and more sophisticated use of contraception among unmarried teenagers. Therefore, contraceptive users represent a significantly higher proportion of the sexually-active teenage population. Yet, there is no disagreement about the fact that a teenager who uses contraception, while certainly not assured of protection from pregnancy, is statistically less likely to become pregnant than one who is sexually active but does not use contraception. In light of these factors, it would be reasonable to expect the pregnancy rate among sexually-active teenagers to decline as contraceptive use increased. Yet even this modest and purely illusory gain did not materialize.

According to the figures Kantner and Zelnik collected on the rate of premarital pregnancy among sexually-active metropolitan-area teenagers — even leaving aside, as Wattleton does, the increase in the rate of sexual activity which has been the chief cause for the increase in the overall teenage pregnancy rate — the pregnancy rate has moved steadily upward. In 1971, 28.1% of the metro-area interview subjects who had ever experienced premarital intercourse had at least one

premarital pregnancy. By 1976, this figure stood at an even 30%. By 1979, it had accelerated even more rapidly to 32.5%.[30]

The very evidence to which Wattleton had pointed as proof of the success of the birth control programs which her organization has so strenuously promoted, and from which it receives such a large proportion of its income, is shown to be untrue according to research published by her own organization. It is no wonder that Wattleton stated her claim as a bald assertion without any statistical or documentary support. The only available statistical research on the subject demonstrated that her claim — as limited and qualified as it was — was untrue.

Wattleton's flimsy claims were certainly not sufficient to insure the reauthorization of the Title X programs in a Congress which was becoming increasingly uncertain of the social utility of those programs. So Planned Parenthood devoted the entire May/June, 1981 issue of *Family Planning Perspectives* to building a case for the extension of these programs. The centerpiece of that issue was an article by Jacqueline Darroch Forrest, Albert I. Hermalin and Stanley K. Henshaw, entitled "The Impact of Family Planning Clinic Programs on Adolescent Pregnancy."[31]

Although the title of the article refers to adolescent pregnancy, the authors confine themselves to an analysis based only on the number of live births to teenage women in the years 1970 and 1975. Their calculations take no account at all of the total number of pregnancies in this age group. This is a crucial omission, for it was between these two dates that abortion was legalized. Both proportionally and numerically, more teenage pregnancies in 1975 ended in abortion than had so resulted in 1970. Thus, between the two selected dates, the authors are able to show a decline in the number and rate of births to teenage mothers, even though the total number of pregnancies to teenagers increased rather than declined during this period.

It was necessary for the authors' purpose to demonstrate a decline in the teenage birth rate in order to show a positive impact for the family planning clinics. But even their statistical sleight-of-hand in counting only live births rather than all pregnancies would not have produced the desired result had the authors not compounded their misrepresentation by treating marital births as equivalent to out-of-wedlock births.

The decline in the rate and number of live births to teenagers between 1970 and 1975 was entirely attributable to a reduction in fertility among married women in this age group. Births to married women of any age do not constitute a social problem and do not justify massive government intervention, especially during a time when the total fertility rate was declining to a level well below that theoretically necessary to maintain the present population. If a married woman chooses to become a mother, that is simply none of the business of Planned Parenthood, the federal government or anyone else.

What does constitute a public problem, and what prompted the federal government to establish and maintain the rather drastic policy of providing birth control services and sex counseling to minors without regard to age or marital status, is the prevalence of pregnancies and births among unmarried teenagers. And during the period under investigation, both the rate and the number of out-of-wedlock births to teenagers increased significantly. The number of live births among unmarried teenagers rose by 17% between 1970 and 1975, while the out-of-wedlock birth rate in this age group increased by 9%.[32] These increases are modest in comparison with the leap in the rate and number of pregnancies among unmarried teenagers, which was camouflaged to a great extent by the increased recourse to abortion.

It is difficult to ascertain how many abortions were performed on teenagers in 1970. The Center for Disease Control's official estimate of 61,000 is probably unrealistically low. On the other hand, a recent Alan Guttmacher Institute estimate of 190,000 is certainly too high.[33] The AGI estimate assumes a total number of 600,000 abortions in 1970; yet there can be no doubt that the legalization of abortion has prompted a sharp increase in the number of abortions — the total doubled within the first five years after the Supreme Court decisions of 1973 — so it is extremely unlikely that the 1970 abortion total was anywhere near this level, which was almost as high as the AGI's own estimate of 740,000 in 1973. Whatever total is accepted, it is estimated that 90% of abortions in this age group were performed on unmarried teenagers.

Even taking the inflated AGI estimate of abortions and adding it to the 191,000 out-of-wedlock teenage births in 1970, the total number of abortions plus live births among unmarried teenagers comes to 362,000, or about 43 per thousand. Using the lower CDC abortion estimate, the comparable figures are 246,000, or 28 per thousand.

In 1975, there were 223,000 live, out-of-wedlock births and 323,000 abortions among teenagers. If 90% of those abortions were on unmarried women, the number and rate of out-of-wedlock births, plus abortions, climbed to 514,000, or 55 per thousand.

This has been the real trend in premarital teenage pregnancy — an increase of at least 30% and perhaps almost 100% in just five years. If Forrest, Hermalin and Henshaw had been interested in honestly assessing the impact of family planning clinic programs on adolescent pregnancy, these are the realities with which they would have had to contend. But they were interested in grantsmanship. They were interested in concocting a plausible rationale to salvage a lucrative government program that was in jeopardy because it had proved to be a catastrophic failure. They were interested in palming off a glib success story to editors, educators and politicians who were all too eager to believe that the emperor really was wearing a new suit of clothes.

So, thanks to the precipitous decline (29%) in the birth rate among

young, married women,[34] the authors were able to claim that teenage fertility had decreased in conjunction with the establishment of the national family planning clinic program. The greater part of their article is devoted to an explanation and application of four separate mathematical models to this truncated data base for the purpose of determining how great a share in this fertility decline could be attributed to the family planning clinics. The result of these sophisticated calculations is the rather modest claim that one birth a year is averted for every ten clients enrolled in a clinic.[35] On this basis, they assert that 119,000 births to teenage women were averted in 1976 as a result of clinic activities in 1975.

It is at this point that the authors' deceptive manipulation of statistics enters the realm of sheer and brazen dishonesty. On the basis of 1976 figures on the outcome of unintended premarital pregnancies among teenagers, they note that only 36% of such pregnancies ended in a live birth. Therefore, Forrest, Hermalin and Henshaw claim that the 119,000 "averted" births represent only 36% of the total number of premarital teenage pregnancies that were "averted" as a result of the family planning clinic programs. Thus, they give the programs credit for having averted 331,000 teenage pregnancies in 1976, 172,000 of which would have ended in abortion and 40,000 in miscarriage. They then extrapolate these extravagant claims throughout the whole decade, and conclude that no less than 2.6 million unintended teenage pregnancies and 1.4 million abortions were averted as a result of the activities of family planning clinics.[36]

If one accepts the tainted claim that the clinic programs had "averted" 119,000 1976 births to teenage mothers, these extrapolations appear to have some plausibility. At least the arithmetic is correct. But a closer examination of these claims reveals that the statistics have been so subtly manipulated that it is difficult to imagine that this was not a deliberate distortion of the truth.

The reason why the authors were able to claim that any births had been "averted" is that more pregnancies than ever before were being aborted. In 1970, certainly fewer than half, and perhaps as few as one-fourth of the out-of-wedlock pregnancies among teenagers ended in abortion. By 1975, there were 1.4 abortions for each live out-of-wedlock birth. It has been the legalization and subsequent widespread use of abortion — and not the more regular use of contraception — that has kept the teenage birth rate from soaring during the 1970's. One abortion can, and almost always does, succeed in "averting" one live birth, but there is no way that it can also be credited with averting an additional 1.4 abortions and .4 miscarriages. Abortion has proven to be the one effective method of "averting" out-of-wedlock births among teenagers, but by reading the figures backward, the authors would have us believe that this method of birth prevention has also succeeded in "averting" a greater number of abortions.

To see the absurdity of this logic, we need only look at how the figures would have appeared if the relative distribution of live births and abortions had remained static between 1970 and 1975. Let us assume hypothetically that the actual number of abortions on unmarried teenagers in 1970 was 128,000 — a figure approximately midway between the Center for Disease Control estimate and the Alan Guttmacher Institute estimate, and roughly equal to two-thirds the number of out-of-wedlock births. This yields a total of 320,000 births plus abortions among unmarried teenagers, 40% of which were aborted.

Five years later, the total of premarital births plus abortions was 514,000. If only 40% of them had been aborted, there would have been about 308,000 live births out-of-wedlock, or 85,000 more than actually occurred. If there had been 85,000 more live births, then the number of births "averted" would have been only 34,000. And if the number of abortions represented only two-thirds the number of live births, a mere 22,000 abortions would have been "averted."

Conversely, let us imagine that the promotion of abortion as the solution to premarital teenage pregnancy had been even more successful than it was in 1975, and that pregnant, unmarried teenagers had obtained 81,000 more abortions than they did. In this case, the number of births "averted" would have risen to 200,000; the number of out-of-wedlock births which actually occurred would have declined to 142,000, and the number of abortions would have increased to 372,000. That means that each live birth would have been equal to 2.6 abortions, so that the number of "averted" abortions would have come out to be more than 500,000. A marvelous system of accounting, in which more is less and less is more!

It is hard to believe that Forrest, Hermaline and Henshaw were doing anything but pulling off an intellectual swindle with their claim that the family planning clinic program has "averted" abortions. These programs have not contributed to preventing abortions. They are not an alternative to abortion. They have been, on the contrary, one of the chief factors responsible for the vertiginous increase in abortions among teenagers. Abortion, in turn, has been a safety valve for these programs, siphoning off the evidence for the disasters they have wrought in the areas of social welfare and public health.

It is quite evident that the existence of these clinic programs has coincided with an unprecedented increase in the incidence of premarital teenage pregnancy. As we shall show in the concluding section, this has not been a mere coincidence. But even leaving that point aside, no one disputes the fact that the clinic programs have been directly responsible for the more widespread use of contraception among teenagers. And it is amply clear from the statistics gathered by Kantner and Zelnik that these improvements in contraceptive use have not been effective in reducing the pregnancy rate among even the most conscientious users. But Kantner and Zelnik also discovered that

young women who become pregnant while using contraception are almost twice as likely to seek an abortion as those who become pregnant in the absence of contraception.[37] In this respect, it is clear that the family planning programs have contributed directly to an increase in the rate of abortion among teenagers.

This result was not unforeseen in the inner circles of the family planning establishment. In January, 1971, *Family Planning Perspectives* published a special 24-page feature entitled "Illegitimacy: Myths, Causes and Cures" by Phillips Cutright.[38] In it, Cutright acknowledged that abortion was the only certain method of reducing the rate of out-of-wedlock births among teenagers.

On the basis of ample empirical evidence, Cutright concluded that "school-based [sex] education programs will not decrease illicit pregnancy rates," but he suggested that "one obvious contraceptive 'education' program in which the schools might profitably engage . . . is to post the name, address, telephone number and clinic hours of the birth control clinics in the community which provide services to unwed minors."[39] In fact, in the intervening years, Planned Parenthood and other family planning agencies have gone one better than Cutright's suggestion, using sex education classes for guest appearances at which contraceptive techniques are explained and demonstrated and clinic programs for teenagers are promoted, and by hiring "peer counselors," students who are paid to recruit their classmates into the clinic programs.

Yet Cutright had no illusions about the effectiveness of birth control clinics in reducing the rate of pregnancy among teenagers. He had examined several such programs in the South for the U.S. Commission on Population Growth and the American Future and discovered that they had not been effective in reducing the rate of teenage pregnancy.[40] Nevertheless, he favored the establishment of such clinics. He insisted that they provide services to unmarried minors on the same basis as to married adults, and that they not be limited to serving low-income persons, because he felt that would place a stigma on their clients and deter some people from enrolling in them. At the same time, he considered it particularly important that these clinics be government-sponsored, not necessarily because of the financial burden of providing family planning services to all comers, but because his studies of such clinics had convinced him that government sponsorship was necessary to overcome what he termed the "pseudo-moral barrier" to contraceptive use among potential clients. He commented that "the government program may have legitimated use of contraception among persons who had moral reservations about birth control, and accomplished this because the program provided manifest evidence that contraception is approved by the established authorities."[41] These recommendations, too, have been fully complied with in the years since Cutright's article appeared.

Recognizing that even with the establishment of comprehensive and

sophisticated birth control clinic programs, there would still be a high number of unintended pregnancies among unmarried teenagers, Cutright advocated the availability of abortion on request as a necessary backup in the event of contraceptive failure. This recommendation, of course, has also been implemented.

The three-pronged agenda which Cutright enunciated and which Planned Parenthood has so effectively implemented to reduce the out-of-wedlock birth rate among teenagers was fully in place by the mid-70's. Schools and other institutions were encouraging young people to participate in family planning clinic programs, and by implication, stamping a seal of authoritative approval on premarital sexual activity. The clinics were making of those young people conscientious users of the most advanced contraceptive methods and, at the same time, confirming them in their sexually-active behavior patterns. The conventional wisdom was that there is nothing inherently wrong with premarital sex as long as it is "responsible sex," that is, sterile sex. Cutright had said as much in the concluding paragraph of his article: "The supposed ill effects of premarital sex . . . have never been documented, so long as premarital sex did not lead to an illicit pregnancy that was carried to term. It is the control of these unwanted pregnancies — not the control of premarital sex — that is the problem." Imbued with this advice, amply warned of the disastrous consequences of giving birth out of wedlock, and accustomed to seeking medical solutions to their "reproductive health" needs, young people dutifully trooped off to the abortion clinics in ever-increasing numbers as the promise of contraceptive protection proved false for them and they found themselves unintentionally pregnant.

The whole system, fueled by tens of millions of federal dollars, was operating like clockwork. There was just one hitch. The rate of out-of-wedlock births among teenagers, the one social problem which the whole apparatus had been constructed to remedy, continued to increase. The reason for this is that Cutright, Planned Parenthood, the federal government and all the others who had promoted sex education plus birth control plus abortion as the solution to the problem of teenage pregnancy, had made one miscalculation. The approval of premarital intercourse which was implicit in the whole system had such an overwhelming effect on teenage sexual behavior that the increase in sexual activity and consequently of premarital pregnancy was so phenomenal that it surpassed the limits of effectiveness of the birth control and abortion clinics in holding down out-of-wedlock births. Since the birth control clinic programs were initiated a decade ago, we have witnessed staggering increases in the rates of premarital pregnancy, abortion, out-of-wedlock births, venereal diseases and the related problems of suicide and other forms of aberrant and self-destructive behavior among teenagers.

Obviously, the root of this problem has been the increase in sexual

activity among teenagers. The question is: would this increase have occurred anyway, or is it something that was provoked by the existence of the birth control programs? In other words, has Planned Parenthood simply failed to do good, or has it actually created a serious public health and social problem?

The typical response of the Planned Parenthood people is simply to disavow all responsibility for leading young people into self-destructive behavior patterns. They point to the survey which shows that over 35% of the clinic patients are sexually active before they come to the clinic,[43] and use this as evidence to show that they are simply meeting a need that already exists. As for the sudden and sharp increase in sexual activity among teenagers, that is the fault of the media and our sex-saturated society, but Planned Parenthood certainly has nothing to do with it. They even tell teenagers it's all right to say no.

This abdication of responsibility is flimsy and unconvincing, but its refutation lies not only in statistical evidence, but more importantly, in psychological observation.

First, the change in sexual attitudes and behavior among teenagers during the 1970's has been so sudden and so drastic that it is very difficult to recall, ever in history, such a dramatic shift in morality. Such a major effect demands a major cause. Yet the general social climate of the 1970's was relatively conservative in comparison with that of the previous decade. There is no doubt that America in the 1970's was permeated with sexuality, and the impact of this cultural environment in shaping moral attitudes cannot be discounted. But the same could be said of America in the 1960's. In fact, the '60s tended to be more strongly anti-authoritarian, more experimental and more rebellious than the '70s. The films and songs of the '70s were no more suggestive than those of the previous decade, and the fashions in clothing were, if anything, more modest. Moreover, during the course of the '70s, the cultural climate tended to become gradually more conservative, while premarital sexual activity among teenagers grew at ever-increasing rates.

The cultural climate argument, therefore, is not a satisfactory explanation for the massive attitudinal and behavioral change among teenagers in the decade. One need not eliminate this as a factor in drawing that conclusion. It is clear that such a complex effect would be the result of a great number of cultural, economic, political and educational factors, and it would be naive to single out any one factor as the reason, in mechanical cause-effect fashion, for the increase in teenage sexual activity. But the need is not to isolate the cause of this change, but rather to assess the effect of birth control programs on attitudes and behavior. It is instructive in this regard to note that the most significant difference in the social environment of teenagers between the '60s and the '70s has been the growth of birth control clinics, and that this growth has very closely paralleled the increase in sexual activity.

Having demonstrated that the explanation offered by Planned Parenthood is not satisfactory, we may now turn to a direct consideration of the impact of the clinics on teenage sexual behavior.

Even as late as 1979, a majority of teenage women had avoided the possibility of pregnancy by abstaining from premarital intercourse. In 1971, before the family planning clinic network was having a substantial impact on attitudes and behavior, this course of action was followed by nearly three out of four teenage women, and historically, premarital sexual abstinence has been the rule rather than the exception for American teenagers. This pattern of behavior found several sources of social support, but the combination of sex education programs which appear to condone premarital intercourse, publicly-funded programs to dispense contraceptives to unmarried minors, and legalized abortion tend to erode those very supports.

Among these social supports have been the attitudes of authority figures, including parents; religious teachings and the civil law; the attitudes and behavior of the peer group; and the fear of pregnancy.

Since the establishment of birth control clinics for teenagers, major authority figures such as teachers, public health officials and popular entertainers have largely given up exhorting teenagers to remain abstinent, in favor of encouraging them to use sex "responsibly," that is, to avoid having babies. Members of the so-called "helping professions" as well as the public authorities seem to have accepted Cutright's conclusion that only out-of-wedlock childbearing, but not premarital sexual activity, is a legitimate problem. Meanwhile, parents and religious leaders have tended to be intimidated, at least to some extent, into tacitly conceding this point because of the impression that premarital sexual activity is inevitable and, if it may be undesirable, it is better to be protected than pregnant.[44] This impression is fostered by dogmatic assertions such as that of Kantner and Zelnik that "It is fairly safe assumption that sexual activity among adolescents is unlikely to decline."[45] In reality, there is no reason to believe that this assumption represents some iron-clad law of human behavior, especially in view of the recent and quite dramatic changes in the sexual behavior of teenagers. It is at least within the realm of possibility that, given the proper social supports, what has gone up can come down.

The support that civil law formerly gave to premarital abstinence through such devices as laws against fornication and statutory rape is undercut by the fact that these laws are rarely enforced (and are, perhaps, unenforceable) and that the very same civil authority subsidizes the distribution of free contraceptives to unmarried minors, thereby providing manifest evidence that fornication and statutory rape, even if they remain technically illegal, are indeed approved and even encouraged by the established authorities.

Parents and religious beliefs still provide significant authority figure support for abstinence, even if not as vocally as in former times. Yet

the counseling process in the birth control clinics directly undermines this support. Because the medical confidentiality required by federal family planning regulations has been consistently interpreted by family planning providers as prohibiting the notification of the parents of minors served in the clinics, many parents are not even aware that their children are involved in these programs and, hence, have no opportunity to offer counsel to their children in this question.[46] Moreover, in the counseling process young people are commonly urged to formulate their own moral guidelines in abstraction from the ethical principles they have learned from their parents or religious instructors. Some observers have also noted a marked anti-parent bias in the literature family planning agencies distribute to teenagers,[47] and this certainly tends to diminish the weight of parental authority.

Peer pressure is of tremendous importance to adolescents struggling to achieve an identity independent of the family, yet generally not mature enough to be self-directed. The fact that premarital sexual activity is more prevalent than ever before is important in this respect; but of even greater importance is the attitude within the peer group toward this sexual activity. While teenage boys have traditionally approved of sexual activity — although for the most part vicariously — girls have not.[48] The sexually-active high school girl has had to pay the heavy price of a bad reputation, social ostracization, and a damaged self-esteem. The sexual revolution has muted these consequences, but only to a degree.

Many family planning agencies have taken to hiring "peer counselors," teenage boys and girls who tell their friends about the benefits of sex and contraception and refer them to the clinics. This confers high status on peers who, in other circumstances, might have appeared as somewhat disreputable, and it helps to create a fear among the sexually-abstinent that they are not "with it" — the ultimate social rejection for a teenager.

The most forceful motivation for sexual abstinence has been the fear of pregnancy. This, in fact, is obviously a major component of authority-figure opposition to premarital intercourse and the strongest rationalization for resistance to peer pressure. Sorenson found that, even among sexually-experienced girls, a majority would be deterred from intercourse by the possibility of pregnancy, as would nearly half the sexually-experienced boys.[49] Moreover, family planning professionals acknowledge that fear of pregnancy is by far the leading stimulant to participation in an organized birth control program.[50] Of course, the very existence of these programs and the public acceptance of them are consequences of the fear of teenage pregnancy, engendered by alarmist literature claiming that this has reached "epidemic" proportions.[51]

Yet fear of pregnancy is precisely what the birth control clinics eliminate with their illusory, but psychologically reassuring, promise

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of contraceptive protection. Teenagers, and in many cases their parents, have been led to believe that if they simply follow the instructions of the family planning counselors, they will not get pregnant. And if they do, a safe, legal abortion is the logical backup measure. This belief has become the very definition of sexual responsibility.

With authority-figure opposition to premarital intercourse either bypassed, muted or won over to the other side; with peer-group attitudes cultivated to foster approval of premarital intercourse; and with the fear of pregnancy rendered inoperative, there would appear to be no rational basis for abstinence left. The operation of birth control clinics, offering free contraceptive counseling and services to teenagers without regard to age or marital status, and without any parental involvement, simply cuts the ground out from under the informal social supports for premarital sexual abstinence. In light of these factors, it is surprising that the incidence of premarital sexual activity is not even more prevalent than the rates reported. The prediction of Kantner and Zelnik may prove correct, if these influences are permitted to continue affecting the attitudes and behavior of teenagers. For in that case, the trend toward increased sexual activity among teenagers can be expected to go on until it reaches a saturation point.

One effect of these factors is to introduce formerly abstinent teenagers into sexual activity. But of equal significance is their tendency to confirm non-virgin teenagers in a sexually-active behavior pattern.

The categorization of teenagers as "sexually active" if they have ever had intercourse is too crude to give an accurate representation of the true level of sexual activity, and the consequent risk of pregnancy, among teenagers. It fails to take account of the fact that many teenagers feel deeply ambivalent about their sexual involvement, and that a significant number of them, after an initial incident or series of sexual encounters return to a pattern of abstinence, often until marriage. This phenomenon, known as "secondary virginity,"[52] has undoubtedly helped to hold down the rate of pregnancy among teenagers classified as "sexually active," simply because a certain proportion of those so classified have not currently been at risk of pregnancy. This has probably been a rather substantial proportion of all those who are considered "sexually active." In their 1976 survey, Kantner and Zelnik found that one-seventh of those young women so classified had experienced intercourse only one time, and that half of their interview subjects who were sexually experienced had not had intercourse at all within the month prior to interview.[53]

Constance Lindemann, a Los Angeles nurse and counselor who provided family planning services to over 2,000 teenagers, wrote *Birth Control and Unmarried Young Women* on the basis of her experience.[54] She notes that the typical pattern of young women seeking family planning services is that the first sexual encounter was unplanned, unintended and regretted. For some time after this, the

typical young woman tries to resist further sexual involvement and refuses to admit to herself that she is really sexually active. Sexual encounters are sporadic and accidental. All this comports with the findings of Sorenson, and it also helps to explain why such a large percentage of clinic patients have some sexual experience before they seek professional birth control assistance.

The next stage in the typical behavior pattern, according to Lindemann, is the approach to a professional. This is symbolically important to the young woman in that it involves a frank self-admission that she is sexually active. One of the chief objectives of the family planning counselor is to resolve the feelings of ambivalence and remove any feelings of guilt over illicit sexual activity on the part of young patients. The counselor tries to lead the young patient to accept his or her sexually-active lifestyle because one of the preconditions to effective contraception is a commitment to what the family planning industry calls "responsible sexuality" — that is, sex without babies. The young person who has guilty or ambivalent feelings about his or her sexual activity is a poor candidate for effective contraceptive use.[55]

Thus, a direct result of the clinic counseling is to obviate, or at least to diminish the likelihood of a return to abstinence and, in most cases, to increase the frequency of intercourse among clinic clients, and hence to increase their exposure to the risk of pregnancy.

In 1978, Planned Parenthood of Detroit published the results of a study of its high-school-aged clients, aimed at showing that participation in the clinic program did not lead to promiscuity. They questioned an entering group of clients about the number of partners and frequency of intercourse within the previous month, and a year later asked the same questions of the same group of young women. The results showed that, after a year in the clinic program, the young women had approximately the same average number of current sexual partners (1.1), but that their frequency of intercourse had increased by more than half from 4.3 to 6.8 times per month.[56]

More recently, surveys of 1,200 teenagers enrolled in organized birth control programs revealed that young women anticipated having intercourse about 50% more frequently after enrollment in the program than before. Among those clients who were sexually active before enrollment in the programs, the average frequency of coitus in the month prior to enrollment was 4.2 times, but the average frequency anticipated for the month following enrollment was 6.3 times.[57]

Both of these studies suggest that involvement in the clinic program directly contributes to more frequent sexual activity. This, of course, increases the exposure of risk to pregnancy and at least partially offsets the less-than-perfect protection afforded by the contraceptives dispensed by the clinic.

These factors help to explain why the incidence of unintended

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pregnancy is so alarmingly high among unmarried teenage contraceptive users. Nevertheless, even by 1979, after a decade of intensive promotion of contraception among teenagers, it is still true that a slight majority of the premarital pregnancies among teenagers occurred among non-users of contraception.[58] These teenagers, at least, did not have any direct involvement in the birth control clinic programs, so is it not possible to absolve the birth control industry of responsibility for this segment of the teenage pregnancy problem? They, after all, were not deluded into exposing themselves to the risk of pregnancy by the false promise of contraceptive protection because they did not use contraception.

In this connection, the research of Kristin Luker into the motivation of abortion patients is instructive.[59] Luker surveyed women who had obtained abortions in the San Francisco Bay area to find out why they had exposed themselves to the risk of an inconvenient pregnancy. Working on the assumption that abortion is not, in itself, a desirable objective of deliberate action, and recognizing that reliable methods of contraception, consistently used, would have reduced the likelihood of an inconvenient pregnancy, Luker asked these women why they had allowed themselves to become pregnant. She found, in most cases, that the decision not to contracept was a conscious choice, but not a carefully-calculated choice. It was the same kind of every-day, risk-taking behavior involved in smoking cigarettes, in spite of the widespread acknowledgement that this can cause cancer, or driving without a seat belt, in spite of the recognized exposure to injury this involves. The women Luker interviewed simply did not think they would become pregnant. But if they did, they knew that the problem could be taken care of with a "safe," legal abortion. The availability of legal abortion, in itself, was an inducement to this risk-taking behavior. Luker went to great lengths to argue that this type of risk-taking was not really abnormal behavior, but the sort of thing that nearly everyone does at one time or another. We know that we might break a leg skiing, but we ski anyway. We know that if we drink too much we might get sick, but we drink anyway. Just so, these women knew they might become pregnant, but they exposed themselves to that risk anyway. After all, they probably would not become pregnant, and if they did, a remedy was available. *Taking Chances*, the title of Luker's book, summarizes her thesis: that it is normal for people to take chances, especially when they perceive the negative consequences of their acts as remote and remediable.

This general psychological observation seems to be applicable to the risk-taking involved in premarital sexual activity. Within the peer group, fear of pregnancy is no longer a major motivational factor in favor of sexual abstinence, thanks to the general knowledge among teenagers of contraceptive availability. Moreover, certain significant authority figures (government, media, teachers and, in some cases,

even parents) project the impression that premarital sexual activity is normal, healthy and inevitable. Finally, the existence of birth control clinics and of abortion clinics provides a sense of security even among those teenagers who do not avail themselves of those services.

Early sexual activity tends to be unpremeditated and sporadic. The likelihood of pregnancy at any given time is relatively small. And if sexual activity becomes a habit, then professional family planning help can be sought. These factors all militate toward risk-taking behavior, and successful risk-taking behavior promotes more risk-taking. I did not get pregnant last time, reasons the teenager, so I probably won't this time, and if this becomes a regular thing, I can always go down to the clinic and get on the pill.

Luker gives us the theoretical model for this psychological pattern, and Kantner and Zelnik give us empirical evidence that this is the actual behavioral pattern among most sexually-active, non-contraceptive teenagers.

In their 1976 survey, Kantner and Zelnik asked those teenagers who had become pregnant while not using contraception, why they had not used a contraceptive. One might imagine, from the tenor of Planned Parenthood propaganda promoting more birth control clinics for teenagers, that the expected answer would be a lack of availability or knowledge about contraception. This was not the case at all, however. Only one interview subject claimed that she could not obtain contraception.[60] The overwhelming majority of these respondents said that they simply did not think they would become pregnant. It was a classic case of "taking chances."

It is impossible to say how many of these teenagers would have taken this chance, would have exposed themselves to the risk of pregnancy, in the absence of a national network of government-funded birth control centers. Similarly, it is impossible to say how many of those teenagers who were contraceptive users would have been sexually active, and how frequently they might have had intercourse, in the absence of these programs. It is virtually certain, however, that these levels would be significantly lower than they are today because, in so many ways these programs can be seen as a major factor in increasing the likelihood of sexual activity among all teenagers, including even those who have no direct involvement in the programs. And, of course, it is this sudden increase in sexual activity among unmarried teenagers which has caused the rate of premarital pregnancy to skyrocket over the past decade.

The conclusion to which all this evidence leads is that these birth control programs have not only been disastrously ineffective in attempting to achieve their ostensible goal of reducing the level of premarital teenage pregnancy, but that they have also been a major factor in exacerbating that problem to such an extent that it is becoming a social crisis.

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IMPLICIT VALUES

The New Sex Education

BY DIANE RAVITCH

ALTHOUGH some parents still adamantly oppose any kind of sex education in our schools, opinion polls have shown repeatedly that a large majority of them favor it. They recognize that in a culture saturated with sexually exploitative commercialism, it is desirable for adolescents to have scientifically valid knowledge about human reproduction.

The case for sex education rests in significant measure on the hope that it will curb certain modern problems resulting from increased sexual activity among teenagers, particularly venereal disease and pregnancies that lead to abortions, illegitimate births or unwanted marriages. Most parents appear to expect their children to be taught the dangers of premature sexual activity, and to be encouraged to exercise responsibility and restraint in the face of peer pressure.

Yet we continue to read of communities embroiled in bitter disputes over sex education, suggesting that there may be grounds for even an intelligent, open-minded, enlightened person to have doubts about its present form. And a look at several of the textbooks now being widely used reveals that, indeed, what parents expect frequently is not what their children are getting. For while few who are not involved realize it, there is today a new, very different philosophy of sex education. Its practitioners speak disparagingly of merely teaching human reproduction and providing information about venereal disease and contraception, calling this "the plumbing." Their course, usually called "human sexuality," deals not only with the physical side of sex, often including explicit instruction in how to perform various maneuvers, but also with young people's feelings and values. It is at the center of most current sex education controversies.

Textbooks of the new sexuality have two constants: first, that where sexual practices are concerned, there is no such thing as right and wrong; second, that "sex roles" identified with being masculine and feminine are learned behavior, and there are probably no real differences between men and women other than in the shape of their sexual organs.

Even among these textbooks, though, presentations vary. Peter Kelman and Burt Sasson's *Modern Human Sexuality*, for example, is restrained in its content and illustrations compared to others because it doesn't show children how to perform sex acts. Instead, the focus is on encouraging young people to think through what to do in a given situation, since what is right for one person may not be right for another.

Thus there is the problem of whether two 15-year-olds, Kathy and Kenny, should have intercourse on their next date. Some of Kathy's friends "mentioned the risk of pregnancy, venereal disease," etc., but another friend "felt that sex strengthened a relationship." Kathy herself worried that Kenny might brag about it or that her parents might find out. The readers are told they can help the couple make their decision. Discuss the matter in small groups. Think of opinions for and against Kathy and Kenny going "all the way." Other issues, like abortion, are similarly presented as problems having no right answers, only opinions, which each person chooses for himself or herself.

Then there are the liberated textbooks. They include every imaginable kind of

DIANE RAVITCH, *adjunct associate professor of history and education at Teachers College, Columbia University, is the author of* The Great School Wars: New York City, 1805-1972 *and* The Revisionists Revised: A Critique of the Radical Attack on the Schools.

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sexual activity to prove that everything is acceptable, that anything two (or more) people do to each other sexually is good as long as it feels good. These books are implicitly engaged in sexual consciousness-raising: they try to remove any sense of embarrassment or guilt about sex, and to demonstrate that once-forbidden activities are actually quite commonplace. In their effort to demystify sex, they offer explanations of how certain activities are performed and illustrations of, say, an erect penis, or the vagina of a spread-eagled female.

Learning About Sex by Gary Kelly is such a textbook used by young adolescents, probably (to judge by its oversimplified language and condescending tone) eighth and ninth graders. One exercise suggested for the teacher is to write on the board such terms as "penis, vagina, intercourse, masturbation, etc. Have students give you lists of slang words they know for each of the proper terms." In the event they don't know the slang words, Kelly includes most of them in the text. Students are also encouraged to share with others in the class how they feel when they touch their body all over, and how they feel when they have some "alone time" and think about their bodies, their sex organs, and their sex drive.

The view that there is no right and wrong, normal or not normal, comes through undiluted in a chapter called "Different Strokes for Different Folks." Here the young reader learns that just as some people prefer "mushrooms, caviar, wines, and spinach," some choose to be homosexuals, transvestites, transsexuals, etc. Among the "preferences" that people have are sadomasochism, and this "may be very acceptable to sexual partners who agree on what they want from each other. The only dangers lie in possible physical injury to another person or in forcing a partner into acts in which he or she does not wish to participate." Still others prefer sexual intercourse with animals: "There are no indications that such animal contacts are harmful, except for the obvious dangers of poor hygiene, injury by the animal or to the animal, or guilt on the part of the human."

IN THE CHAPTER that deals with sexual intercourse, "mutual masturbation," oral sex, and anal sex, Kelly warns in the teacher's guide that "many young people no longer consider debating the pros or cons of premarital sex to be a reasonable pursuit. They may feel that for young people the question was resolved long ago, and adults just try to perpetuate the controversy."

For the students, Kelly lists the pros and cons of "sex outside marriage." On the negative side (drawing of sad young man), it might lead to unwanted pregnancy; venereal disease; unexpected emotional involvement; or "guilt and regret" caused by conflict with the "moral codes of their parents or their religion." This is bad because "guilt doesn't help young persons to feel good about themselves. . . ." On the plus side (drawing of happy young woman), sexual activity outside of marriage is a way of experiencing "the pleasure of sexual sharing"; "feeling good about your body"; "deepening the sense of intimacy and caring"; "learning about sexual functioning"; and "learning about sexual responsibility." Because the reader already knows how to avoid VD and pregnancy, the scales are heavily tilted toward the emotional and educational benefits of "sex outside marriage," so long as there is not too much conflict with the parents' moral code or religion—the happy assumption being that the student has no personal moral code other than wanting to feel good.

In *Changing Bodies, Changing Lives* Ruth Bell, a member of the Boston Women's Health Collective, nicely captures the spirit of peer pressure on behalf of her book's liberated views. While other authors occasionally cite research studies as their authority, she quotes teenagers to show how they feel and what they want to know. Nothing is left to the imagination. The text explains how to masturbate and how it feels; shows in six easy steps how to use a condom; tells how to "come out" if you are gay, how to have homosexual sex, and how to meet other gay people; describes oral sex and how it feels; and offers lots of hints on improving your techniques.

One work that concerns family issues in detail is John and Erna Perry's *Pairing and Parenthood*, used by high school seniors and college students. Like the other books, it makes a strong argument against "sex roles." This comes across powerfully in a picture of an adorable girl of about four wearing a long calico dress and a bonnet; the picture itself says nothing in particular, but the caption reads, "The sad eyes of this child dressed in poke bonnet, long skirt, and spotless pinafore seem a reflection of the spiritual and physical confinement of such symbols of femininity."

The Perry book uses poll data to persuade its readers that premarital sex and extramarital sex are commonplace. A primary purpose of sex among the young, they say, is to improve communication. We all know from Holden Caulfield and other adolescents how difficult communicating is for teenagers. The Perrys quote a 16-year-old girl who advises, "Maybe you should ball first, then talk, then ball again. Because I find that I've got a whole new basis for having sex with somebody, you know, after balling gets us to talking together."

Since the focus of their book is marriage and the family, the Perrys' ideas on fidelity bear thinking about. Sexual infidelity, they say, "is likely to create disturbances in a marriage, especially if it is discovered by the other partner." Nevertheless, studies show that sexual infidelity is widespread, and "a number of commentators have pointed out that an affair actually may benefit a marriage." In fact, readers are told, one study "concluded that the institution of marriage cannot satisfy all of the needs of both spouses, and that marriage partners often are pleased that they do not have to satisfy every whim of their mates." To settle the matter, the authors note that "more liberal religious spokesmen also have played down the negative aspects of extramarital sex...."

The Perrys become truly creative on the subject of "swinging," or couples exchanging sexual partners. These activities, they say, "are generally viewed as a means of satisfying sexual needs for diversity." Swinging is not "infidelity," they hold, because the people in-

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volved are honest with each other. For those who "adhere to a more traditional moral code," such practices as divorce and remarriage, group marriage and swinging may seem like "evidence that the moral strength of our culture is decaying." Not to worry, assure the Perrys, "these new lifestyles . . . can be considered attempts to modify traditional marriage—to adapt it to the changing demands of modern life, rather than to destroy the institution."

Of course, the Perrys are not altogether wrong, and they may actually be on to something important when they say that the new lifestyles are an adaptation to "the changing demands of modern life." In *The Asymmetric Society*, published earlier this year, the sociologist James Coleman described what he believes is a fairly drastic change that is taking place in the nature of our social structure—from one where most transactions occurred between individuals, to one where most communications occur among corporate actors. The corporation is composed of positions, in which individuals are interchangeable, and our society is rapidly becoming characterized by corporate, rather than individual, activities. In this emerging society, the family is an anachronism from another age, because it is made up of persons, not positions.

I cannot do justice to Coleman's fascinating analysis of "the asymmetric society" in this short space, but I think the implications of the new sex education for his concept are clear. The new sex educators are engaged in liberating children from the hold of their families: from their moral codes and religious beliefs, and their personal control. The educators are liberating young people from the idea that marriage requires sexual fidelity, too, thus preparing them for the new society in which sexual partners can be exchanged as readily as corporate managers change jobs.

It is not surprising that some parents sense this and do not like it. There has been concern as well that the new sex education encourages sexual activity. One former advisor to a Planned Parenthood program, Dr. Hans H. Neumann, medical director of the New Haven, Connecticut, Department of Health, wrote in the May 24, 1982, issue of *Medical Economics* that, "instead of teaching young people how to avoid an unwanted pregnancy and its consequences, we're teaching them that the joy of sex is their human birthright.' Frankly, it would be difficult to see how teenagers could spend a semester reading how to do it right, how good it feels when you do it, and how meaningful the experience is, without wanting to try it as soon as possible.

THERE ARE other reasons to wonder about the new sex education, not the least being its setting within compulsory public education. The latest report from the National Center for Education Statistics is that nearly 50 per cent of all high school seniors take a sex education course, although there is no way of knowing how many of these use the "old" or the "new" approach). Is it appropriate for the government to teach its citizenry how to masturbate? to explain how to perform cunnilingus? to reassure them that infidelity is widespread?

Education is usually thought of as a process leading someone to new knowledge or understanding. There is always some shaping and directing involved on the part of those who teach. In sex education, the new notion is to go with the flow, if human beings do it, then it is natural and right. Of course, human beings do lots of things that we don't approve of and we expect teachers to say so. We expect teachers to say that racism, sexism, theft, drug use, and murder are unacceptable, even though they are widespread in human experience.

I could be wrong, but I believe most people support sex education in the polls because they think their children are learning the old-fashioned course, "the plumbing." They think their children are being taught the dangers of premature sexual activity and the importance of the family to a life of happiness and fulfillment. What they are getting, in an unknown number of districts, is a course in the new narcissism.

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